Medicare Annual Wellness Assessment

Patient. Name: _____ Date:_____

DOB: _____ Spoken Language:_____

Who is completing this form: □ myself □ family member □ friend □ other _____

Rate your overall health: □ excellent □ very good □ good □ fair □ poor

How many times per week do you do the following? (Select the answer)

1. Engage in physical activity (e.g. walking, cycling, etc.) for at least 20 to 30 minutes? □ 0 □ 1 – 2 □ 3 – 4 □ >5

2. Include strength exercises (weights or resistance bands) in your physical activity routine? □ 0 □ 1 – 2 □ 3 – 4 □ >5

3. Eat 5 or more servings of fruits and vegetables (one serving equals

1/2 cup)? □ 0 □ 1 – 2 □ 3 – 4 □ >5

4) Eat 5 or more servings of grains (one serving equals one slice of

bread, 1 cup of cereal, etc.)? □ 0 □ 1 – 2 □ 3 – 4 □ >5

5) Eat 2 or more servings of dairy products (milk, yogurt or cheese)? □ 0 □ 1 – 2 □ 3 – 4 □ >5

6) Eat fast food? □ 0 □ 1 – 2 □ 3 – 4 □ >5

7) Cut the size of your meals or skip meals because you don't have enough food (not enough money or enough help to shop or cook)? □ 0 □ 1 – 2 □ 3 – 4 □ >5

8) Have more than one drink of alcohol (beer, liquor, wine) per day? □ 0 □ 1 – 2 □ 3 – 4 □ >5

9) Get at least 7 hours of sleep? □ 0 □ 1 – 2 □ 3 – 4 □ >5

10) Use tobacco or nicotine products (cigarettes, e-cigarettes, smokeless tobacco, cigars, or pipes) or are close to others who do? □ 0 □ 1 – 2 □ 3 – 4 □ >5

11) Leave your home to run errands, go to work, go to meetings, classes, church, social functions, etc. (not counting doctor's visits)? □ 0 □ 1 – 2 □ 3 – 4 □ >5

12) Have physical pain that affects your activities? □ 0 □ 1 – 2 □ 3 – 4 □ >5

13) Do you visit your dentist for regular check-ups at least every six months if you have natural teeth, or once a year i you have full dentures? □ Yes □ No

14) Do you have enough money to pay for the medications, medical supplies, and medical visits that you need? □ Yes □ No

15) About how many times in the last month have you missed taking your medications? _____ times □ I don't take medicines

16) About how many times in the last month have you taken your medication differently than prescribed by your doctor? (skip if you don't take medicines) _____ times

17) Do you take any over-the-counter medications (vitamins, supplements, herbal medicines)? □ Yes □ No

18) Do you have sufficient transportation to make all of your medical appointments? □ Yes □ No

19) In the past 12 months, have you had any problem with balance or walking, or have you had any falls? If Yes to falls, how many times?_____ □ Yes □ No

20) In the past 6 months, have you had a problem with leakage of urine? □ Yes □ No

21) In the past month, have you needed help managing your finances? □ Yes □ No

22) Do you think anybody is taking or using your money without your permission? □ Yes □ No

23) In the past 7 days, have you needed help from others:

24) To eat, bathe, get dressed or use the toilet? □ Yes □ No

25) To do laundry, cooking, housekeeping or shopping? □ Yes □ No

26) For transportation? □ Yes □ No

27) To take your medications? □ Yes □ No

28) Do you or your caregiver have sufficient help/support with and resources for caregiving duties? (skip if you do not give or receive care) □ Yes □ No

29) Are you satisfied with your current level of social interaction with family and friends, and participation in activities outside your home? □ Yes □ No

30) Do you have family and friends who care about you and you can count on for help when you need something or have a problem? □ Yes □ No

31) Is anybody mistreating you? □ Yes □ No

32) Do you have an Advance Directive or Living Will? □ Yes □ No

Over the last two weeks, how often have you been bothered by the following problems? □ not at all □ several days □ > half of the days □ nearly every day

33) Little interest or pleasure in doing things? □ not at all □ several days □ > half of the days □ nearly every day

34) Feeling down, depressed or hopeless? □ not at all □ several days □ > half of the days □ nearly every day

35) Having anxiety or stress about your health, finances, family, work or social relationships? □ not at all □ several days □ > half of the days □ nearly every day

For Provider Use Only

Height: _____ Weight: _____ BMI: _____ BP: ____/____ P:_____

PHQ -2 Score: ____ PHQ-9 Score (if indicated):_____

Other mental health screen, if indicated: (name/score) _____

Mini-Cog Score: _____ Other cognitive screen, if indicated: (name/score) _____

Timed Up and Go: _____

□ Home safety checklist reviewed

□ Personal Preventive Plan completed and reviewed with patient

Information/education provided:

□ Exercise □ Healthy Eating □ Dietary supplements □ Food Banks/Meals on Wheels

□ Fall prevention □ Pain □ Depression □ Sleep

□ Cognitive impairment □ Medication use □ Transportation resources

□ Caregiver resources □ Abuse prevention □ Scam prevention

□ Veteran's benefits □ Health Insurance Counseling Advocacy Program(HICAP)

□ Speech/hearing center □ Braille Institute □ Advance Directive/Living Will

□ Adult Day Care □ Alzheimer's Association □ Long Term Support Services (LTSS)

□ Other _____

Referrals made/provided:

□ Dental □ Optometry □ PT evaluation □ Pain management □ Dementia evaluation

□ Psychiatry/Counseling/behavioral health □ Dietician/nutrition counseling

□ Bone Mineral Density □ Colonoscopy □ Mammogram □ Pap smear

□ Alcohol reduction □ Tobacco cessation □ Chronic Disease Self-Management Class

□ Case management □ Driving evaluation □ Friendly visitor program

□ Other _____