Annual Wellness Visit

Medicare covers an Annual Wellness Visit (AWV) providing Personalized Prevention Plan Services (PPPS) at no cost to the beneficiary, so beneficiaries can work with their providers to develop and update a personalized prevention plan. This **new benefit** will provide an ongoing focus on prevention that can be adapted as a beneficiary's health needs change over time. The first year, we will gather all essential information through your Annual Well Visit. Following your AWV, we will provide Subsequent Wellness Visits (SWV) to continue your PPPS, medical history, medical care, impairments, risk factors and intervention.

Please complete the following questionnaire **before** meeting with your provider. Your provider will use this information to create a wellness plan for you. Please answer all questions to the best of your ability.

DEMOGRAPHICS

Name _____ Date of birth _____

What is your Age: ☐ Under 65 ☐ 65-69 ☐ 70-79 ☐ 80 or older?

Are you: ☐ Male ☐ Female

What is your race? (**Check all that apply**)

- □ White
- □ Black or African American
- □ Asian
- □ Native Hawaiian or Other Pacific Islander
- □ American Indian or Alaskan Native
- □ Hispanic or Latino origin or descent
- □ Other

BEHAVIORAL RISK FACTORS

A. PHYSICAL ACTIVITY/EXERCISE

How many days per week do you exercise?

_____ Per week _____ minutes/day _____ I do not exercise (go to section B)

How would you rate the intensity level of your exercise program?

_____ Light (ex., slow walk, stretching) _____ Moderate (ex., brisk walking, golfing, bowling)

_____ Vigorous (ex., jogging, swimming, biking, heavy lifting)

In the **past four weeks,** have you been bothered by any of the following problems

- □ Falling or Dizzy
- □ Sexual Problems
- □ Trouble Eating
- □ Teeth or Denture Problems
- □ Using the Telephone
- □ Tiredness or Fatigue

During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

- □ Very heavy
- □ Heavy
- □ Moderate
- □ Light
- □ Very Light

During the **past four weeks,** how much bodily pain have you generally had?

- □ No pain
- □ Very mild pain
- □ Mild pain
- □ Moderate pain

On a typical day, how many hours of sleep do you usually get?

_____ hours per day

During the **past four weeks**, how would you rate your health in general?

□ Excellent □ Good □ Poor
□ Very Good □ Fair

B. SMOKING/TOBACCO USE

Do you currently smoke cigarettes or cigars or use any other type of tobacco product?

_____Yes _____Yes, but I'm not ready to quit

_____Yes and I might quit _____ No

Are you a former smoker or have you used any other type of tobacco product?

_____ Yes, smoker _____Yes, other type of tobacco product

How long ago did you quit?

_____ Months _____ Years

C. ALCOHOL USE

During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

□ 10 or more drinks per week □ One drink or less per week
□ 6-9 drinks per week □ No alcohol at all
□ 2-5 drinks per week

D. NUTRITION/DIET

On a typical day, how many servings of fruits and vegetables do you consume?

_____ Servings per day

In a typical week, how many servings of fried or high in fat (such as cheese, fatty meat) do you consume?

_____ Servings per week

In a typical week, how many servings of high fiber or whole grain foods do you consume?

_____ Servings per week

How confident are you that you can control and manage most of your health problems?

□ Very Confident □ Not Very Confident
□ Somewhat Confident □ I do not have any health problems

E. MOTOR VEHICLE SAFETY

Do you wear your seat belt when in the car?

□ Yes □ No

Are you having difficulties driving your car?

□ Yes, often □ No
□ Sometimes □ Not applicable, I don't use a car

Can you get to places out of walking distance without help? (Example, can you travel alone on buses, taxis, or drive your own car)

□ Yes □ No

F. HOME SAFETY

Do you have smoke detectors in your home and routinely change the batteries?

□ Yes □ No

Do you have a fire extinguisher and know how to use it properly?

□ Yes □ No

Have you been given any information to help you with the following?

Hazards in your house that might hurt you?

□ Yes □ No

G. ACTIVITIES OF DAILY LIVING

During the **past four weeks,** was someone available to help you if you needed and wanted help? (Example, if you felt nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; help with daily chores; or needed help just taking care of yourself)

□ Yes, as much as I wanted
□ Yes, quite a bit
□ Yes, some
□ Yes, a little
□ No, not at all

Do you need assistance with any of the following? Check all that apply.

_____Dressing
_____ Prepare Meals
_____ Using the restroom
_____ Bathing
_____ Walking
_____ Shopping
_____ Food Preparation
_____ Housekeeping
_____ Driving
_____ Organizing daily medications
_____ Handling Finances

H. FALL RISK

Do you have any of the following in your home?

_____ Stairs
_____ Throw rugs
_____ Pets
_____ Damaged flooring

Have you fallen two or more times in the **past year?**

□ Yes □ No

Are you afraid of falling?

□ Yes □ No

GENERAL HEALTH

I. SUN EXPOSURE

Do you protect yourself from over exposure to the sun when outdoors?

□ Yes □ No

J. HEIGHT/WEIGHT

What is your height? _____ in. What is your weight? _____ lbs.

At your last physician visit, how would you rate your blood pressure?

_____ Low to Normal
_____ Borderline High
_____ High
_____ Do not know
_____ I have not had my blood pressure taken for some time

At your last physician visit, how was your cholesterol reading, if done?

_____ Normal, Below 200
_____ Borderline, Between 200-239
_____ High, 240 or higher

_____ Do not know/not sure
_____ I have not had my cholesterol checked in the past year

At your last physician visit, how was your blood glucose (sugar) reading?

_____ Normal, Below 100
_____ Borderline, Between 100-125
_____ High, 126 or higher

_____ Do not know/not sure
_____ I have not had my blood glucose (sugar) checked in the past year

Do you suffer from chronic pain on a daily basis?

□ Yes □ No

K. Medications

How often do you have trouble taking medicines the way you have been told to take them?

□ I do not have to take medicine
□ I always take them as prescribed
□ Sometimes I take them as prescribed
□ I seldom take them as prescribed

Have you been given any information to help you keep track of your medicines?

□ Yes □ No

Please list current prescriptions and non-prescription medicines, vitamins, home remedies, herbs:

Medication/Vitamin/Herb	Date Last Filled

_____
_____
_____
_____
_____
_____
_____
_____
_____

L. PERSONAL / FAMILY HISTORY

Please indicate whether you or a person related by blood has had any of the following medical problems

□ High Blood Pressure Relationship_____
□ Stroke Relationship_____
□ Heart Disease Relationship_____
□ High Cholesterol Relationship_____
□ Diabetes Relationship_____
□ Congestive Heart Failure Relationship_____
□ Heart Attack Relationship_____
□ Glaucoma Relationship_____
□ Cancer Relationship_____
□ Alcoholism Relationship_____
□ Asthma/COPD Relationship_____
□ Depression/suicide Relationship_____
□ Thyroid Problems Relationship_____

M. OTHER MEDICAL CARE

List any other providers who provided medical care or treatment in the last 6 months:

Name	Date	Condition

_____
_____
_____
_____
_____
_____
_____
_____

N. MENTAL WELLNESS

During the **past four weeks,** how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

□ Not at all □ Moderately □ Extremely
□ Slightly □ Quite a bit

During the **past four weeks,** has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

□ Not at all □ Moderately □ Extremely
□ Slightly □ Quite a bit

O. THINKING ABILITY CHANGES

I have noticed a recent decline in my memory. □ Yes □ No

Others (my friends or family) tell me that I am forgetting things they tell me. □ Yes □ No

My ability to concentrate seems to have declined recently. □ Yes □ No

I have suffered recent losses that might hurt some of my thinking abilities. □ Yes □ No

I get confused or easily distracted more than I used to. □ Yes □ No

P. LEG/FEET SYMPTOMS

My leg(s) hurt when I walk long distance. □ Yes □ No

I get cramps in my legs when watching television or sitting still awhile. □ Yes □ No

I notice that my feet get cold or numb when I sit still for a time. □ Yes □ No

Occasionally I get a tingling in my legs or my hands. □ Yes □ No

The sores or wounds on my legs or feet seem to take a long time to heal. □ Yes □ No

Q. GASTRO & AUTONOMIC

Heartburn or Indigestion seems to be a problem now and then.	□ Yes □ No
I get frequent flatulence or abdominal gas discomfort on a regular basis.	□ Yes □ No
I experience abdominal pain, gas or diarrhea after consuming milk products.	□ Yes □ No
I occasionally have trouble with insomnia or falling asleep.	□ Yes □ No
Fatigue and Drowsiness seem to be a common problem for me.	□ Yes □ No
I often get a little lightheaded when I stand quickly after sitting awhile.	□ Yes □ No

_____ _____

Patient Signature Date

TO BE COMPLETED BY PROVIDER