Advocate Health Care

Medicare Annual Wellness Visit Questionnaire

Answering these questions will help you and your health care provider develop a personalized prevention plan to help you stay healthy and plan for future health services.

Date	**Last Name:**	**First Name:**	**Middle Name:**
Date of Birth: / /	**Age:**	**Gender:** □ Male □ Female	
Ethnicity: □ Caucasian □ African American □ Hispanic □ Asian □ Other: _____			
Language spoken in home:			
What is your height? _____feet _____ inches		**What is your weight?** _____pounds	
Allergies (including allergies to medicines) _____			

Please list medicines you are taking. Include all prescriptions, non-prescription, and over the counter (OTC) medicines- including inhalers, vitamins, herbs and supplements.

Medicine Name	How much? (Strength or dose)	Why am I taking?	How often do I take this medicine?	Who ordered this medicine?

Pharmacy Information: Please list the local and mail order pharmacies where you get your prescriptions filled.

Pharmacy	Address	Phone Number	Fax Number
		( )	( )
		( )	( )
		( )	( )

Please list the doctors and providers who are involved in your care.

Name of the doctor/provider	Reason for care	Date last seen	Phone Number
			( )
			( )
			( )
			( )
			( )

Medical Vendors: Please list the agencies that supply your home nursing services or medical equipment.		
Name of Company	**What is supplied**	**Phone Number**
		( )
		( )
		( )

Medical/Family History: Please check the appropriate boxes.					
Disease	**Self**	**Father**	**Mother**	**Brother/ Sister**	**Children**
Alcoholism	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐
Past Illnesses (self):					
Past Hospitalizations (self):					

Please check the appropriate boxes.	*Almost all of the time*	*Most of the time*	*Some of the time*	*Almost never*
In the <u>past 4 weeks</u>, how often have you feel down, depressed, or hopeless?	☐	☐	☐	☐
In the <u>past 4 weeks</u>, how often have you felt little interest or pleasure in doing things?	☐	☐	☐	☐
In the <u>past 4 weeks</u>, how often have your feelings caused you distress or interfered with your ability to get along socially with family or friends?	☐	☐	☐	☐
In the <u>past 4 weeks</u>, how often have you felt nervous, anxious, or on edge?	☐	☐	☐	☐
In the <u>past 4 weeks</u>, how often were you not able to stop worrying or control your worrying?	☐	☐	☐	☐
How often is stress a problem for you in handling your: health, finances, work, family, or social relationships?	☐	☐	☐	☐
How often do you get the social and emotional support you need?	☐	☐	☐	☐
How often do you fasten your seat belt when you are in a car?	☐	☐	☐	☐
In the <u>past 4 weeks</u>, how often have you felt sleepy during the daytime?	☐	☐	☐	☐
How many hours of sleep do you usually get each night?	_____ hours			
Do you snore or has anyone told you that you snore?	☐ Yes		☐ No	

Please check the appropriate boxes or fill in the blank.		
In the <u>past 4 weeks</u>, how much pain have you felt?	□ A lot □ Some	□ None
If your **blood pressure** was checked <u>within the past year</u>, what was it when it was last checked?	□ at or below 120/80 □ 120/80 to 139/89	□ 140/90 or higher □ I'm not sure
If your **cholesterol** was checked <u>within the past year</u>, what was your *total* cholesterol when it was last checked?	□ below 200 □ 200-239	□ 240 or higher □ I'm not sure
If your glucose was checked, what was your **fasting blood glucose (blood sugar)** level the last time it was checked?	□ below 100 □ 100-125	□ 126 or higher □ I'm not sure
If you have diabetes, and if you have had your **hemoglobin A1c** level checked in the past year, what was it the last time you had it checked?	□ 6 or lower □ 7	□ 8 or higher □ I'm not sure
In the <u>past 4 weeks</u>, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?	□ Yes	□ No
In the <u>past 4 weeks</u>, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medicines?	□ Yes	□ No
In general, would you say your health is…?	□ Excellent □ Very Good □ Good	□ Fair □ Poor
How would you describe the condition of your mouth and teeth? (including false teeth or dentures)	□ Excellent □ Very Good □ Good	□ Fair □ Poor
In a typical week, how many days do you exercise?	_____ days per week □ I am currently not exercising	
On days when you exercise, how long do you typically exercise?	_____ minutes per day	
On days when you exercise, how intense is your typical exercise?	□ Light (like stretching or slow walking) □ Moderate (like brisk walking) □ Heavy (like jogging or swimming) □ Very heavy (like fast running or stair climbing)	
In a typical week, how many days do you drink alcohol?	_____ days per week	
In a typical week, how often do you have 4 or more alcoholic drinks on one occasion?	□ Never □ Once a week □ 2-3 times per week	□ More than 3 times per week
Do you ever drive after drinking, or ride with a driver who has been drinking?	□ Yes	□ No
In the <u>past 4 weeks</u>, have you used tobacco? (includes smoking or smokeless tobacco products)	□ Yes (list type)_____	□ No
If you have smoked or used smokeless tobacco products in the <u>past 4 weeks</u>, would you be interested in quitting tobacco use within the next month?	□ Yes	□ No

Please fill in the blank.	
In a typical week, how many servings of fruits and vegetables do you eat each day? (1 serving= 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup= the size of a baseball)	_____ servings per day
In a typical week, how many servings of high fiber or whole grain foods do you eat each day? (1 serving= 1 slice of 100% whole wheat bread, 1 cup of whole- grain or high- fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta)	_____ servings per day
In a typical week, how many servings of fried or high-fat foods do you eat each day? (Examples include: fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise)	_____ servings per day
In a typical week, how many *sugar-sweetened* (not diet) beverages do you consume *each day?*	_____ sugar sweetened beverages per day

You have completed your portion of the Medicare Annual Wellness Questionnaire.
The following pages will be completed by your physician during the appointment.

For Office Use Only:
Comments: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Reviewed by: _____ *Date:* _____

Reference: Sample Health Risk Assessment (A framework for patient-centered health risk assessments- providing health promotion and disease prevention services to Medicare beneficiaries. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.) Available at http://www.cdc.gov/policy/ohsc/hra/

Advocate Health Care

Senior/Medicare Preventive Services Plan

These are typical preventive services and health screenings recommended for individuals 65 years of age and above. Please review these health services with your doctor to see which ones are appropriate for you based on your clinical risk factors and insurance coverage.

Preventive Service	Last Received (Date)	Up-to-date (Yes/No)
One-time Initial Preventive Physical Examination (IPPE)		One-time benefit
Annual Wellness Visit (AWV)		
Abdominal Aortic Aneurysm Screening (if at risk)[1]		
Bone Mass Measurement		
Cholesterol/LDL		
Colorectal Cancer Screenings (any of the following)		
Fecal Occult Blood Test		
Flexible Sigmoidoscopy		
Colonoscopy		
Diabetes Screenings		
Glaucoma Screening		
Hearing Screening		
HIV Screening		
Immunizations (Based on guidelines)		
Flu		
Hepatitis B		
Pneumococcal		
Tetanus[2]		
Tdap		
Zostavax		
Mammogram (screening)		
Pap Test +/- HPV test[3]		
Prostate Cancer Screening Discussion		
Tobacco Use Cessation Counseling		
Vision Screening		
Other		

[1] A Medicare beneficiary with certain risk factors for AAAs may receive a referral for a one-time preventive ultrasound screening for the early detection of AAAs. Important: Eligible beneficiaries must receive a referral for an ultrasound screening for AAA as a result of an IPPE.

[2] Medicare does not cover a Tetanus vaccine for prevention.

[3] Ask your doctor if this is appropriate for you.

You can also track your preventive services on MyMedicare.gov. Get a two-year calendar of the Medicare-covered tests and screenings you are eligible for and print a personalized "on the go" report to take to your next doctor's appointment.