UW Medicine
Women's Health Care Center

Medicare Wellness Visit
Patient Questionnaire

Name _____ **Birthdate**_____

Please fill out this questionnaire to help us cover all areas required for Medicare Wellness Visit.

Please list all members of your current care team outside UWMC (including any medical specialists, eye doctor, alternative medicine providers, physical or massage therapists, medical equipment suppliers):

_____

_____

_____

SELF ASSESSMENT OF HEALTH:

How would you rate your overall health the past 4 weeks? ___Excellent ___Good ___Fair ___Poor

	Yes	No
Can you manage your overall health problems?	( )	( )
Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing or getting around the house?	( )	( )

PSYCHOSOCIAL HEALTH:

Please answer these questions about how you've been feeling in the **past 2 weeks**.

0 = Not at all 1 = several days 2 = more than half of the days 3 = nearly every day

Over the past two weeks, how often have you:	
Felt down, depressed, or hopeless	0 1 2 3
Felt little interest or pleasure in doing things	0 1 2 3
Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?	0 1 2 3
Have you felt stress over health, finances, relationships or work?	0 1 2 3
Do you often get the emotional support you need?	0 1 2 3
Have you had:	
Body pain?	0 1 2 3
Fatigue?	0 1 2 3

Please fill out all 4 pages

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HEALTH AND HABITS:

How many alcoholic drinks do you have in a typical week? ___0 ___1 ____2 to 5 ____More than 5

	Yes	No
Do you eat a balanced diet, including protein, high fiber, fruits & vegetables?	( )	( )
Do you exercise regularly?	( )	( )
Type of exercise _____		
Frequency _____		
Do you always use your seat belt in the car?	( )	( )

How would you describe the condition of your mouth and teeth, including any false teeth or dentures? ___Excellent ___Very Good ___Good ___Fair ___Poor

	Yes	No
Are you sexually active?	( )	( )
Do you find yourself having trouble hearing people speak?	( )	( )
Do you wear a hearing aid/device?	( )	( )
Do you have a fire extinguisher in your home?	( )	( )
Do you have a smoke detector?	( )	( )

ACTIVITIES OF DAILY LIVING:

In your present state of health how much difficulty do you have with the following activities?

Please rate your level of impairment:

0 = None 1= Mild 2 = Moderate 3 = Severe 4 = Complete impairment

Preparing food and eating:	0	1	2	3	4
Bathing yourself:	0	1	2	3	4
Getting dressed:	0	1	2	3	4
Using the toilet:	0	1	2	3	4
Moving around from place to place:	0	1	2	3	4

	Yes	No
In the past year have you fallen or had a near fall?	( )	( )
Do you feel safe in your home environment?	( )	( )

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INSTRUMENTAL ACTIVITIES OF DAILY LIVING:

In your present state of health how much difficulty do you have with the following activities?
Please rate your level of impairment:

0 = No impairment 1 = Mild 2 = Moderate 3 = Severe 4 = Complete impairment

Shopping:	0	1	2	3	4
Using the telephone:	0	1	2	3	4
Housekeeping:	0	1	2	3	4
Laundry:	0	1	2	3	4

0 = No impairment 1= Mild 2 = Moderate 3 = Severe 4 = Complete impairment

Driving or using transportation:	0	1	2	3	4
Managing your own finances:	0	1	2	3	4
Taking your own medications:	0	1	2	3	4

SIGNS OF COGNITIVE IMPAIRMENT:

	Yes	No
Have you experienced any memory issues or problems with thinking?	( )	( )
Have any concerns about your memory been raised by family members, friends, caretakers or others?	( )	( )

CARDIAC RISK FACTORS:

	Yes	No
Do you smoke?	( )	( )
Are you obese?	( )	( )
Do you have diabetes?	( )	( )
Do you have known heart disease?	( )	( )
Do you have a family history of heart disease:	( )	( )
Do you have a sedentary lifestyle:	( )	( )
Do you have hyperlipidemia (High Cholesterol):	( )	( )

SCREENING AND PREVENTIVE SERVICES - Please mark the type of visit you qualify for today:

___ Initial Preventive Physical Exam (IPPE) .....if within first 12 months on Medicare B

___ First Annual Wellness Visit (1st AWV).....if 12 months or more on Medicare B

.....and if 12 months or more since IPPE (if done)

___ Subsequent Annual Wellness Visit (subsequent AWV).....if 12 months or more since last AWV

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SCREENING AND PREVENTIVE SERVICES:

Have you had the listed test or intervention:	**Yes** (with date if outside UWMC)	**No**
Pneumococcal vaccines (Pneumovax, Prevnar, or both):	( ) Date:_____	( )
Influenza vaccine (flu shot):	( ) Date:_____	( )
Hepatitis B vaccine (not all adults need this one):	( ) Date:_____	( )
Screening mammography:	( ) Date:_____	( )
Screening pap smear (last one is usually around age 65):	( ) Date:_____	( )
Colon cancer screening (Colonoscopy, stool cards, or FIT)	( ) Date:_____	( )
Screening for diabetes (glucose or blood sugar testing):	( ) Date:_____	( )
Diabetes self-management training (if diabetic):	( ) Date:_____	( )
Bone density screening:	( ) Date:_____	( )
Screening for glaucoma (eye exam):	( ) Date:_____	( )
Nutrition Counseling:	( ) Date:_____	( )
Cardiovascular screening blood tests (Cholesterol)	( ) Date:_____	( )

End-of-Life planning:	**Yes**	**No**
Do you have a Living Will?	( )	( )
Do you have a Durable Power of Attorney for Medical Affairs?	( )	( )
Would you like to discuss this topic today?	( )	( )

MEDICAL HISTORY UPDATE: If you or any family members (blood relatives) have been diagnosed with a new medical condition since your last annual exam here, please list who & what conditions here:

_____

_____

_____

_____

Thank you for filling out this form! Please return it to the medical assistant or your provider.

Please fill out all 4 pages