UW Medicine
UW NEIGHBORHOOD CLINICS

Medicare Subsequent Annual Wellness Visit

Name _____ **Birthdate**_____

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Please list members of your current care team (Visiting Nurses, Therapies, Durable Medical Equipment Supplier, and any other Medical Clinics, physicians or advanced healthcare providers):

_____

_____

_____

SELF ASSESSMENT OF HEALTH:

How do 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:

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

Over the past two weeks, 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
In the past 2 weeks, have you felt stress over health, finances, relationships or work?	0	1	2	3
Do you often get the emotional support your need?	0	1	2	3
In the past 2 weeks, how much:				
Body pain do you have?	0	1	2	3
Fatigue do you have?	0	1	2	3

HEALTH AND HABITS:

How much alcohol do you drink? ___Never ___Once/week ___2-5 Drinks/Week ____>5/week

	Yes	No
Do you eat a well balanced diet, including protein, high fiber, fruits and 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 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

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?	( )	( )

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 = None 1= Mild 2=Moderate 3=severe 4=complete

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 = None 1= Mild 2=Moderate 3=severe 4=complete

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 been raised by family members, friends, caretakers or others?	( )	( )

CARDIAC RISK FACTORS:

	Yes	**No**
Smoker:	( )	( )
Obesity:	( )	( )
Diabetic:	( )	( )
Known heart disease:	( )	( )
Family history of heart disease:	( )	( )
Sedentary lifestyle:	( )	( )
Hyperlipidemia (High Cholesterol):	( )	( )

SCREENING AND PREVENTIVE SERVICES:

Have you had any of the following?

Pneumococcal vaccine: Date _____

Influenza vaccine: Date _____

Hepatitis B vaccine: Date _____

Screening mammography (women only): Date _____

Screening pap smear and pelvic exam (women only): Date _____

Colorectal cancer screening (Colonoscopy or Hemocult Card): Date _____

Screening for diabetes (Glucose or Blood Sugar testing): Date _____

Diabetes self management training: Date _____

Bone densitometry screening: Date _____

Screening for glaucoma: Date _____

Nutrition Counseling: Date _____

Cardiovascular screening blood tests (Cholesterol) Date _____

End-of-Life planning: Date _____

Would you care to discuss any of the following with your provider?	**Yes**	**No**
Nutrition counseling:	( )	( )
End-of-life planning:		
Living Will:	( )	( )
Durable Power of Attorney for Medical Affairs	( )	( )