**MLK Community Medical Group**

Patient Name: _____

Date of Birth: _____

# MEDICARE ANNUAL WELLNESS QUESTIONNAIRE

**Please complete this checklist before seeing your doctor or nurse.**
Your responses will help us provide the best care. We will also perform a vision test.

**List of current providers you see:** ☐ **None** ☐ **N/A**

1. _____ Condition: _____
2. _____ Condition: _____
3. _____ Condition: _____
4. _____ Condition: _____
5. _____ Condition: _____

**List of current medical equipment suppliers: (oxygen, CPAP, etc)** ☐ **None** ☐ **N/A**

1. _____
2. _____
3. _____
4. _____
5. _____

**List of current supplements:** ☐ **None** ☐ **N/A**

1. _____ Dose: _____
2. _____ Dose: _____
3. _____ Dose: _____
4. _____ Dose: _____
5. _____ Dose: _____
6. _____ Dose: _____

**General Health (check appropriate response)**

1. In general, would you say your health is? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
2. Do you have dental problems that have not received proper attention? ☐ Yes ☐ No
3. Each night, how many hours of sleep do you usually get? _____ # of hours/night
4. Do you snore or has anyone told you that you snore? ☐ Yes ☐ No
5. Have you noticed difficulty with your hearing? ☐ Yes ☐ No
6. Do you have any of the following: ☐ Ringing in the ear ☐ Dizziness ☐ Discharge
7. Have you had a recent eye exam? ☐ Yes ☐ No

**Nutrition**

8. In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? _____# of servings/day
   (one serving = 1 cup of fresh vegetables, 1/2 cup of cooked vegetables, or 1 med piece of fruit)
9. In the past 7 days, how many servings of fried or high fat foods did you typically eat each day? _____# of servings/day
   (examples include fried chicken or fish, bacon, french fries, potato chips, donuts, foods made with cream)
10. In the past 7 days, how many servings of sugar-sweetened (not diet beverages) did you typically consume each day? _____# of servings/day

**Exercise**

11. In the past 4 weeks, how many days did you exercise? _____# of days/week
12. On days when you exercised, for how long did you exercise? _____# of hours/day _____# of minutes/day
13. How intense was your typical exercise?
    ☐ Light (like stretching or slow walking) ☐ Moderate (like brisk walking) ☐ I am currently not exercising
    ☐ Heavy (like jogging or swimming) ☐ Very heavy (like fast running or stair climbing)

**Alcohol**

14. In the last 4 weeks, on average how many drinks of wine, beer or other alcoholic beverages did you drink?
    ☐ None ☐ 1 or less ☐ 2-5 per week ☐ 6-9 per week ☐ 10 or more per week
15. How many times in the last year have you had 4 or more drinks in one day?
    ☐ Never ☐ A few times a year ☐ Monthly ☐ Weekly ☐ Daily or almost daily

**Tobacco**

16. In the past 30 days, have you used tobacco? Smoked: ☐ Yes ☐ No Smokeless tobacco product: ☐ Yes ☐ No
17. Would you be interested in quitting tobacco use within the next month? ☐ Yes ☐ No

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**Depression**

18. In the past 2 weeks, how often have you felt down, depressed, or hopeless?
    ☐ Almost all of the time ☐ Most of the time ☐ Some of the time ☐ Almost never
19. In the past 2 weeks, how often have you felt little interest or pleasure in doing things?
    ☐ Almost all of the time ☐ Most of the time ☐ Some of the time ☐ Almost never

**Home Safety**

20. Does your home have: Rugs in the hallway? ☐ Yes ☐ No Handrails on the stairs? ☐ Yes ☐ No
    Grab bars in the bathroom? ☐ Yes ☐ No Good lighting? ☐ Yes ☐ No

**Activities of Daily Living**

21. In the past 7 days, did you need help from others to perform everyday activities such as sitting, getting dressed, grooming, bathing, walking or using the toilet?
    ☐ Yes ☐ No If yes, which area(s): _____
22. In the past 7 days, did you need help from others to take care of such things as laundry, housekeeping, banking, shopping, food preparation, transportation or taking your medications?
    ☐ Yes ☐ No If yes, which area(s) _____:
23. Do you need help writing checks or managing your finances? ☐ Yes ☐ No
24. Do you always fasten your seat belt when you are in a car? ☐ Yes ☐ No
25. Have you fallen two or more times in the past year? ☐ Yes ☐ No
26. Do you have an advanced health directive or POLST? ☐ Yes ☐ No
    a. If yes, has anything changed? ☐ Yes ☐ No
    b. If no, would you like to receive more information? ☐ Yes ☐ No

**In addition to the no cost Medicare preventive exam, I would like the provider to address the following items:**

I understand that my regular personal copay, deductible and/ or co-insurance will apply as the below is a separate, billable type of visit.

☐ Yes, please reveiw the information below. ☐ No, thank you, not at this time. I have no other concerns regarding my health.

**Chronic Conditions:**

1. _____
2. _____
3. _____
4. _____
5. _____

**Current medication refill requests:**

1. _____
2. _____
3. _____
4. _____
5. _____

**New Problems: (please include symptoms and duration)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

_____ _____

Signature of Patient (if minor, Signature of Responsible Party) Date

_____ _____

Signature of Guardian or Personal Representative Date

_____ _____

Name of Guardian or Personal Representative (print) Relationship to Patient

_____ _____

Signature of Provider Date