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Medicare Annual Wellness Visit

Please help us serve you better at the time of your Medicare Initial Annual Wellness Visit by supplying as much information as possible on the following pages:

Printed Name: _____

Birthdate:_____Date: _____

I. Past Medical History:

A. Allergy: _____

Drug Sensitivity /Intolerance:_____

B. All prior medical history including diseases, hospitalizations, injuries, and surgery (and childbirth if female):

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

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C. Current prescription and non-prescription medications & dosage including vitamins, supplements, and aspirin:

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

D. In the last 12 months, have you ever stopped taking your prescription medications or changed the way you take them because of cost? Yes ☐ No ☐

E. Would you like to discuss lower cost medication options with your doctor? Yes ☐ No ☐

F. Current Physicians and other Healthcare Professionals involved in your medical care:

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

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II. Family History of Medical Problems:

A. Grandparents: Age at death & cause of death IF deceased:

B. Parents: Age at death & cause of death IF deceased:

C. Siblings:

D. Children:

E. Spouse:

F. Other:

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Ill. Social History:

A. Tobacco Use:

_____

B. Alcohol Use:

_____

C. Current Recreational Drug Use:

_____

D. Caffeine Intake:

_____

E. Exercise:

_____

F. Occupation or Former Occupation:

_____

IV. Activities of Daily Living (Please Check Off Your Level of Function below as Independent, Assistance Required or Unable):

	Independent	Assistance	Unable
Telephone:	_____	_____	_____
Shopping:	_____	_____	_____
Driving:	_____	_____	_____
Meal Preparation:	_____	_____	_____
Housekeeping:	_____	_____	_____
Taking medications:	_____	_____	_____
Managing finances:	_____	_____	_____

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V. Safety and Fall Risk Assessment:

	YES	NO
A. Hearing Impairment?		_____
B. Vision Impairment?		_____
C. Have you fallen in the last 6 months?	_____	_____
D. Loose or throw rugs in your home?	_____	_____
E. Seat belt usage?	_____	_____
F. Safety devices in tub or shower?	_____	_____
G. Use Cane, Walker, or wheelchair?	_____	_____
H. Dizziness?	_____	_____
I. Urinary or bowel lack of control?	_____	_____

VI. Depression Assessment:

A. Over the past two weeks, have you felt down, depressed, or hopeless?	_____	_____
B. Over the past 2 weeks, have you felt little interest or pleasure in doing things?	_____	_____

VII. Advance Directives:

We strongly encourage you to complete the following two forms if you haven't already done so:

A. Designation of a Personal Representative (Health Insurance Portability and Accountability Act or HIPAA). Please complete the attachment.

B. Health Care Proxy and instructions for completion. Please complete the attachment.