Medicare Annual Wellness Questionnaire

Complete this before your yearly wellness visit. Choose one answer unless told otherwise. You may write "unsure" or ask to discuss a question privately. Someone may help you. Bring this packet and any medication, screening, or vaccine records. For language, reading, or other assistance, call (208) 247-4279.

FULL NAME	DATE OF BIRTH	TODAY'S DATE

AGE	GENDER	RACE	ETHNICITY

PREFERRED LANGUAGE	HELP NEEDED TO COMPLETE THIS FORM

Who is completing this form? ☐ Patient ☐ Patient with help ☐ Someone for the patient

IF SOMEONE HELPED OR ANSWERED FOR YOU: NAME AND RELATIONSHIP

1 PATIENT CARE TEAM

List your current clinicians and care services, including specialists, mental health care, home care, and medical equipment suppliers. You may attach a current list.

NAME	SPECIALTY OR SERVICE	CLINIC OR LOCATION

☐ Current list attached ☐ No other clinicians or services

2 HEALTH RISK ASSESSMENT

RISK ASSESSMENT

DAYS YOU EXERCISE IN A USUAL WEEK (0 TO 7)	MINUTES OF EXERCISE ON THOSE DAYS

How vigorously can you usually exercise? ☐ Unable ☐ Light ☐ Moderate ☐ Vigorous

In the past month, how often have you had sex?

☐ Not at all ☐ 1 time ☐ 2 to 4 times ☐ 5 or more times ☐ Discuss privately

NUMBER OF SEXUAL PARTNERS IN THE PAST YEAR (or write "discuss privately")

Any sexual health concerns or interest in STI testing? ☐ Yes ☐ No ☐ Discuss privately

GENERAL HEALTH AND PAIN ASSESSMENT

How would you rate your overall health? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Do you feel weak or easily worn out during everyday activities? ☐ Yes ☐ No ☐ Unsure

Have you lost weight without trying in the past year? ☐ Yes ☐ No ☐ Unsure

PATIENT NAME	DATE OF BIRTH

In the past month, how often have you had pain? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

AVERAGE PAIN IN THE PAST MONTH (0 no pain to 10 worst pain)	PAIN LOCATION

In the past month, how much has pain affected each area? Choose one answer per row.

	Not at all	A little	Somewhat	A lot	Extremely
Your work or usual daily tasks	☐	☐	☐	☐	☐
Your ability to walk	☐	☐	☐	☐	☐
Your relationships with other people	☐	☐	☐	☐	☐

DAILY TASKS

How do you currently manage each task? Choose one answer per row, including help from another person.

	Alone, easily	Alone, with difficulty	With help	Unable	Not applicable
Preparing your own food	☐	☐	☐	☐	☐
Bathing or cleaning yourself	☐	☐	☐	☐	☐
Dressing yourself	☐	☐	☐	☐	☐
Using the toilet	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐
Getting around your home	☐	☐	☐	☐	☐
Paying bills	☐	☐	☐	☐	☐
Planning your budget	☐	☐	☐	☐	☐
Doing routine housework	☐	☐	☐	☐	☐

HOME SAFETY AND ASSISTANCE

	Yes	No	Unsure
Do you feel safe in your current home?	☐	☐	☐
Do you feel safe in your neighborhood or community?	☐	☐	☐
Would changes or different housing make you safer?	☐	☐	☐
Do you need more help with daily tasks at home?	☐	☐	☐
Is someone available to help when you need them?	☐	☐	☐

WHO HELPS YOU, AND WHAT EXTRA HELP OR HOME CHANGES WOULD YOU LIKE?

3 DEPRESSION SCREENING

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

PATIENT NAME

DATE OF BIRTH

Have you ever been diagnosed with depression or another mood disorder? ☐ Yes ☐ No ☐ Unsure

4 VISION SCREENING

Do you have trouble seeing, even with glasses or contacts if you use them? ☐ Yes ☐ No ☐ Unsure

LAST EYE EXAM (DATE OR YEAR)

EYE CLINIC (OR WRITE "UNSURE")

5 HEARING SCREENING

Do you have trouble hearing conversations? ☐ Yes ☐ No ☐ Unsure

Do you use hearing aids? ☐ Yes, helpful ☐ Yes, still have trouble ☐ No

6 FALL RISK AND HOME SAFETY

How many times have you fallen anywhere in the past 12 months? ☐ 0 ☐ 1 ☐ 2 or more ☐ Unsure

	Yes	No	Unsure
Were you injured in a fall during the past 12 months?	☐	☐	☐
Do you feel unsteady when standing or walking?	☐	☐	☐
Are you worried about falling?	☐	☐	☐

What do you use to get around? Choose all that apply. ☐ Nothing ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other

MEDICATION REVIEW

List or attach all medicines in section 13 (Form 2). Include prescriptions, over-the-counter medicines, vitamins, and supplements.

Do you currently have an opioid prescription, such as hydrocodone, oxycodone, tramadol, morphine, fentanyl, methadone, or buprenorphine? ☐ Yes ☐ No ☐ Unsure

If yes: have you taken more than prescribed, had strong urges to take extra, or had trouble controlling use? ☐ Yes ☐ No ☐ Discuss privately ☐ Not applicable

IF YOU HAVE PAIN, WHAT TREATMENTS HELP AND HOW WELL DO THEY WORK?

7 PSYCHOSOCIAL RISKS

How satisfied are you with your life? ☐ Very satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very dissatisfied

During the past month, how often have you had the following experiences?

	Never	Rarely	Sometimes	Often	Always
Stress that is hard to manage	☐	☐	☐	☐	☐
Anger that is hard to manage	☐	☐	☐	☐	☐
Loneliness or feeling cut off from others	☐	☐	☐	☐	☐
Tiredness or lack of energy	☐	☐	☐	☐	☐

PATIENT NAME	DATE OF BIRTH

8 BEHAVIORAL RISKS

TOBACCO AND ALCOHOL

Do you use cigarettes, cigars, chewing tobacco, or nicotine vaping products? ☐ Never used ☐ Used in the past ☐ Use now

If you have ever smoked cigarettes, give your usual daily amount and total years smoked below.

PRODUCTS USED	AVERAGE CIGARETTES / DAY	YEARS OF CIGARETTE SMOKING	YEAR QUIT

In the past year, how often did you drink alcohol?

☐ Never ☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times a week ☐ 4 or more times a week

DRINKS ON A TYPICAL DRINKING DAY (OR 0)	MOST DRINKS IN ONE DAY IN THE PAST YEAR (OR 0)

One drink is about 12 oz beer, 5 oz wine, or 1.5 oz liquor.

OTHER SUBSTANCES

In the past year, have you used any of the following? Choose one answer per row.

	Yes	No	Discuss privately
Cannabis or marijuana, including medical use	☐	☐	☐
Illegal or street drugs	☐	☐	☐
Prescription medicines differently than prescribed	☐	☐	☐

Have alcohol or drugs ever caused problems, or have you had trouble cutting down? ☐ Yes ☐ No ☐ Discuss privately

Has a close family member had problems with alcohol or drug use? ☐ Yes ☐ No ☐ Unsure ☐ Discuss privately

NUTRITION AND ORAL HEALTH

How often do your meals include vegetables, fruit, and other nutritious foods? ☐ Usually ☐ Sometimes ☐ Rarely

	Yes	No	Unsure
Do you have trouble getting enough food?	☐	☐	☐
Do you have problems with your teeth, gums, mouth, or dentures?	☐	☐	☐
Do you have trouble chewing or swallowing?	☐	☐	☐

9 ACTIVITIES OF DAILY LIVING

These are additional activities not listed in section 2. How do you currently manage each task?

	Alone, easily	Alone, with difficulty	With help	Unable	Not applicable
Feeding yourself	☐	☐	☐	☐	☐
Grooming, brushing teeth, or combing hair	☐	☐	☐	☐	☐
Using the telephone	☐	☐	☐	☐	☐
Doing laundry	☐	☐	☐	☐	☐
Getting to places outside your home	☐	☐	☐	☐	☐
Taking the correct medicines at the right times	☐	☐	☐	☐	☐

PATIENT NAME

DATE OF BIRTH

10 COGNITIVE SCREENING

	Yes	No	Unsure
Have you noticed worsening memory or thinking?	☐	☐	☐
Has anyone close to you raised concerns about your memory?	☐	☐	☐

IF YES, WHAT CHANGES HAVE YOU OR OTHERS NOTICED?

11 ADVANCE CARE PLAN

These questions are optional. An advance directive records your wishes for care or names someone to make medical decisions if you cannot speak for yourself.

Do you have an advance directive, living will, or health care power of attorney? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to answer

If yes, where is a copy? ☐ Already at this office ☐ I will bring a copy ☐ Unsure ☐ Not applicable

Would you like to discuss your future care wishes at this visit? ☐ Yes ☐ No ☐ Unsure

PERSON YOU WOULD WANT TO HELP MAKE MEDICAL DECISIONS

RELATIONSHIP AND PHONE

Writing a name here does not create a legal power of attorney. Bring existing advance care documents for review.

Medical & Social History Update

Tell us what has changed since your last wellness visit. If this is your first visit here, include your past history. You may attach a current history or records instead of rewriting them.

PATIENT NAME	DATE OF BIRTH

12 MEDICAL AND SOCIAL HISTORY

☐ No changes to history already on file ☐ History or records attached ☐ Updates listed below

MEDICAL CONDITIONS (include mental health and substance use conditions)

OPERATIONS, HOSPITAL STAYS, ER VISITS, MAJOR INJURIES OR NEW TREATMENTS (include dates)

ALLERGIES AND REACTIONS

☐ No known allergies ☐ No changes to the list on file ☐ Updated list attached

MEDICINE OR OTHER SUBSTANCE	REACTION

FAMILY HISTORY

List important conditions in parents, brothers, sisters, or children, including heart disease, stroke, diabetes, cancer, memory disorders, mental illness, or substance use problems. Include age at diagnosis if known.

☐ No changes to history on file ☐ Family history unknown ☐ Information listed below

RELATIVE	CONDITION	AGE AT DIAGNOSIS

SOCIAL HISTORY

Who do you live with? ☐ Alone ☐ Spouse or partner ☐ Family or others ☐ Care facility

Your current work status ☐ Working ☐ Retired ☐ Unable to work ☐ Other

PATIENT NAME	DATE OF BIRTH

13 MEDICINES AND SUPPLEMENTS

List all current prescriptions, over-the-counter medicines, and supplements (including vitamins, calcium, and herbs), even those used only as needed. Attach a current list or bring the containers if easier.

☐ I take no medicines or supplements ☐ Complete current list attached ☐ List below

If you use an attached list, include the name, strength, amount, how often you take it, and who prescribes it. Add another sheet if needed.

MEDICINE OR SUPPLEMENT	STRENGTH AND AMOUNT TAKEN	HOW OFTEN	PRESCRIBER

	Yes	No	Unsure
Do you have side effects or concerns about any medicine?	☐	☐	☐
Is cost or getting refills making it hard to take medicines?	☐	☐	☐
Do you need help keeping track of your medicines?	☐	☐	☐

SOCIAL HISTORY, CONTINUED

How often do you wear a seat belt in a vehicle? ☐ Always ☐ Sometimes ☐ Never ☐ Do not ride in vehicles

Do you or others have concerns about your driving? ☐ Yes ☐ No ☐ Do not drive

How do you usually get to places outside your home? Choose all that apply.

☐ Drive myself ☐ Ride with others ☐ Bus, taxi or rideshare ☐ Walk, bike or wheelchair ☐ Other ☐ No reliable transportation

Preventive Care History

Write the most recent date or year, or write “never,” “unsure,” or “not applicable.” Include where it was done if known. You may attach records. Your clinician will decide which tests or vaccines you need.

PATIENT NAME	DATE OF BIRTH

14 SCREENINGS AND VACCINES

PRIOR TESTS AND SCREENINGS

TEST OR SCREENING	DATE OR STATUS	WHERE DONE OR RESULT
Prior heart tracing (EKG or ECG), if any		
Abdominal aortic aneurysm ultrasound		
Prostate screening (PSA blood test or exam)		
Breast cancer screening (mammogram)		
Cervical cancer screening (Pap or HPV test)		
Bone density test (DEXA)		
Cholesterol testing		
Diabetes screening (glucose or A1c)		
Colorectal screening (also name the test)		
Sexually transmitted infection testing		
Lung cancer screening (low-dose CT)		
Hepatitis C screening		
HIV screening		

VACCINE HISTORY

Give last date; add type and number of doses if known. Write “never” or “unsure,” or attach records.

VACCINE	DATE / DETAILS	VACCINE	DATE / DETAILS
Pneumonia		Influenza (flu)	
Tetanus / Td / Tdap		Shingles	
COVID-19		RSV	
Hepatitis B		Other vaccine	

YOUR PRIORITIES

WHAT HEALTH CONCERN OR GOAL WOULD YOU MOST LIKE TO DISCUSS?

LANGUAGE ASSISTANCE

Notice of Availability of Language Assistance & Auxiliary Aids

Free language assistance services and auxiliary aids and services are available to you. This notice appears in English and in the fifteen languages most commonly spoken by individuals with limited English proficiency in Idaho.

English: ATTENTION: Language assistance services and auxiliary aids and services are available to you free of charge. Call (208) 247-4279.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (208) 247-4279.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (208) 247-4279。

Srpski (Serbian): OBAVJEŠTENJE: Ako govorite srpski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (208) 247-4279.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (208) 247-4279 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (208) 247-4279.

العربية (Arabic): ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 247-4279 (208).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (208) 247-4279.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (208) 247-4279.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (208) 247-4279.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (208) 247-4279.

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(208) 247-4279 まで、お電話にてご連絡ください。

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (208) 247-4279.

Ikirundi (Kirundi): ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona (208) 247-4279.

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. با 247-4279 (208) تماس بگیرید.

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (208) 247-4279.

To request an interpreter, a document in another format (such as large print, braille, audio, or an accessible electronic format), or any other accommodation, call (208) 247-4279 or ask any staff member. There is never a charge for these services.