Medicare Wellness Visit Patient Questionnaire

In the last year, have you had any of the following? If Yes, please explain.

Illness No Yes _____

Injury No Yes _____

Surgery No Yes _____

Hospital stay No Yes _____

Family History – please mark any conditions in your immediate family:

	NO	YES	Father	Mother	Brother	Sister	Grandparent
Alcoholism							
Anemia, Sickle Cell							
Arthritis							
Bleeding Disorders							
Cancer							
Diabetes							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease							
Mental Health							
Obesity							
Seizures							
Stroke							
Thyroid Disease							
Tuberculosis							

Dentist: _____ Last Dental Appt: _____

Eye Doctor: _____ Last Eye Appt.: _____

Please list any other healthcare providers outside Medical Associates Clinic that you've seen in the past year_____

1. Do you smoke? _____Never smoked ____Current smoker, # packs per day_____
   _____Former smoker, Year you quit smoking _____
2. Do you drink alcohol?
   ____ Non-drinker _____ Current alcohol user, # of drinks per week _____
3. Do you drink caffeine?
   _____ No caffeine _____ Current caffeine user, # of caffeine drinks per day ____
4. Do you use sunscreen? _____ Yes _____ No

(continued)

5. Do you have a history of excessive sun exposure? _____ Yes _____ No
6. In general, how would you rate your diet? _____ Good, healthy _____ Average _____ Poor
7. Do you exercise? _____ No _____ Yes, # of days per week _____
8. Are you sexually active? _____ Yes _____ No
9. Over the last 2 weeks, have you felt down, depressed or hopeless? Yes No
10. Over the last 2 weeks, have you felt little interest or pleasure in doing things? Yes No
11. Do your feelings cause distress or interfere with your ability to interact socially with family and/or friends? Yes No
12. Is stress a problem for you? Yes No
13. Have you ever been treated for depression? Yes No
14. How many hours do you usually sleep at night? _____
15. In general, would you rate your health as:
    _____ Excellent _____Very Good _____Good _____Fair _____ Poor
16. Do you need help with dressing, eating, bathing or toileting? Yes No
17. Do you have trouble with walking, climbing stairs or falls? Yes No
18. Do you have trouble hearing the television or radio when others do not? Yes No
19. Do you have to strain or struggle to hear or understand conversations? Yes No
20. Do you live alone? Yes No
21. Does your home have rugs in the hallway, lack handrails on the stairs or have poor lighting? Yes No
22. Do you need help with phone, transportation, shopping or preparing meals? Yes No
23. Do you need help with housework, laundry, medications or managing money? Yes No
24. Does your home lack functioning smoke alarms? Yes No
25. Do you always fasten your seat belt when you are in the car? Yes No
26. Do you have Advance Directive or Living Will? Yes No