Professional Village Family Medicine

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Medicare Annual Wellness Visit

Please fill out and bring to your Annual Wellness Visit (i.e. your "6 Month Check")

Failure to bring to your appointment will result in your appointment being rescheduled

This is not your Complete Physical

Your Name:	Your Date of Birth:	Date of Visit:

Please list the names of all physicians that you see:	
Name:	Specialty:

Please list all of your medications/supplements (if more room is needed, please write on separate piece of paper:	
Medication/Supplement:	Dose/Frequency:

Have any of your family members had a change in their health? If so, please explain.

*If you have an Advanced Directive or living will, please bring a copy to your visit *

1	During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue? □ Not at all □ Slightly □ Moderately □ Quite a bit □ Extremely
2	During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups? □ Not at all □ Slightly □ Moderately □ Quite a bit □ Extremely
3	During the past four weeks, how much bodily pain have you generally had? □ No pain □ Very mild pain □Mild pain □Moderate pain □Severe pain
4	During the past four weeks, was someone available to help you if needed and wanted help? (For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.) □Yes, as much as I wanted □Yes, quite a bit □Yes, some □Yes, a little □ No
5	During the past four weeks, what was the hardest physical activity you could do for at least two minutes? □ Very heavy □ Heavy □ Moderate □ Light □ Very light
6	Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car? □ Yes □ No
7	Can you go shopping for groceries or clothes without someone's help? □ Yes □ No
8	Can you do your own housework without help? □ Yes □ No
9	Can you prepare your own meals? □ Yes □ No
10	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? □ Yes □ No
11	Can you handle your own money without help? □ Yes □ No
12	During the past four weeks, how would you rate your health in general? □ Excellent □ Very good □ Good □ Fair □ Poor
13	Are you having difficulties driving your car? □ Yes, often □ Sometimes □ No □ I don't drive
14	How often duing the past four weeks have you been bothered by : Falling/dizzy when standing up □Never □Seldom □Sometimes □Often □Always Sexual problems □Never □Seldom □Sometimes □Often □Always Trouble eating well □Never □Seldom □Sometimes □Often □Always Teeth or denture problems □Never □Seldom □Sometimes □Often □Always Problems using the telephone □Never □Seldom □Sometimes □Often □Always Tiredness or fatigue □Never □Seldom □Sometimes □Often □Always
15	Have you fallen two or more times in the past year? □ Yes □ No
16	Are you afraid of falling? □ Yes □ No
17	Do you exercise for about 20 minutes three or more days a week? □ Yes, most of the time □ Yes, some of the time □ No, I usually do not exercise this much
17	Have you been given, at any point by anyone, information to help you with the following? Hazards in your house that might hurt you? □ Yes □ No Keeping track of your medications? □ Yes □ No
18	How often do you have trouble taking medicines the way you have been told to take them? □ I do not have to take medicine □ Sometimes I take them as prescribed □ I always take them as prescribed □ I seldom take them as prescribed
19	How confident are you that you can control and manage most of your health problems? □ Very condient □ Not very confident □ Somewhat confident □ I do not have any health problems
20	Are you worried about your memory? □ Yes □ No