

Welcome to Medicare Physical Questionnaire

- Welcome to Medicare (1st year of Medicare eligibility)
 - Annual Wellness Visit (Initial- 2nd year of Medicare)
 - Annual Wellness Visit (Subsequent- 12 months after last AWV)
- Date of Last Wellness Visit: _____ Location/MD _____

Patient's Name _____ Date of Birth _____

Today's Date: _____ Part B eligibility date: _____ Allergies _____

Current problems _____

Past Medical and Social History:

Past illnesses, injuries, hospitalizations	Date	Hospitalized?

Do you use?	Yes/No	If yes, how much, how often, what type?
Alcohol		
Tobacco		
Drugs		

Current List of Providers (including specialists) and Suppliers

Name of Provider	Specialty	Reason

Family History (CIRCLE all that apply)

Alcoholism	Cancer	High Cholesterol	Seizures
Anemia, sickle cell	Diabetes	Hypertension	Stroke
Arthritis	Heart Disease	Obesity	Thyroid Disease
Bleeding disorders	Liver Disease	Kidney Disease	Tuberculosis

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Depression Screening:

(please circle)

- | | | |
|--|-----|----|
| 1. Over the last two weeks, have you felt down, depressed, or hopeless? | YES | NO |
| 2. Over the last two weeks, have you felt little interest or pleasure in doing things? | YES | NO |

If you answered yes to either of these please complete the 13 questions below. If you did NOT answer yes to either of the questions above, please proceed to the Hearing Loss Screen.

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|---|-----|----|
| 1. Are you basically satisfied with your life? | YES | NO |
| 2. Have you dropped many of your activities and interests? | YES | NO |
| 3. Do you feel that your life is empty? | YES | NO |
| 4. Do you often get bored? | YES | NO |
| 5. Are you in good spirits most of the time? | YES | NO |
| 6. Are you afraid that something bad is going to happen to you? | YES | NO |
| 7. Do you feel happy most of the time? | YES | NO |
| 8. Do you often feel helpless? | YES | NO |
| 9. Do you prefer to stay at home, rather than going out and doing new things? | YES | NO |
| 10. Do you feel you have more problems with memory than most? | YES | NO |
| 11. Do you think it is wonderful to be alive now? | YES | NO |
| 12. Do you feel pretty worthless the way you are now? | YES | NO |
| 13. Do you feel full of energy? | YES | NO |

Hearing Loss Screen:

- | | | |
|--|-----|----|
| 1. Do you have trouble hearing the television or radio when others do not? | YES | NO |
| 2. Do you have to strain or struggle to hear/understand conversations? | YES | NO |

Functional Screen:

- | | | |
|---|-----|----|
| 1. Do you need help preparing meals, transportation, shopping, taking your medicine, managing your finances, or other activities of daily living? | YES | NO |
| 2. Do you live alone? | YES | NO |

Home Safety Screen:

- | | | |
|---|-----|----|
| 1. Does your home have throw rugs, poor lighting, or a slippery bathtub/shower? | YES | NO |
| 2. Does your home LACK grab bars in the bathroom, handrails on stairs or steps? | YES | NO |
| 3. Does your home LACK functional smoke alarms? | YES | NO |

Advanced Care Planning:

- | | | |
|---|-----|----|
| 1. I consent to discuss end-of-life issues with my healthcare provider? | YES | NO |
| 2. Do you have an Advance Directive? | YES | NO |
| 3. If no, would you like to discuss Advance Directives at your appointment? | YES | NO |