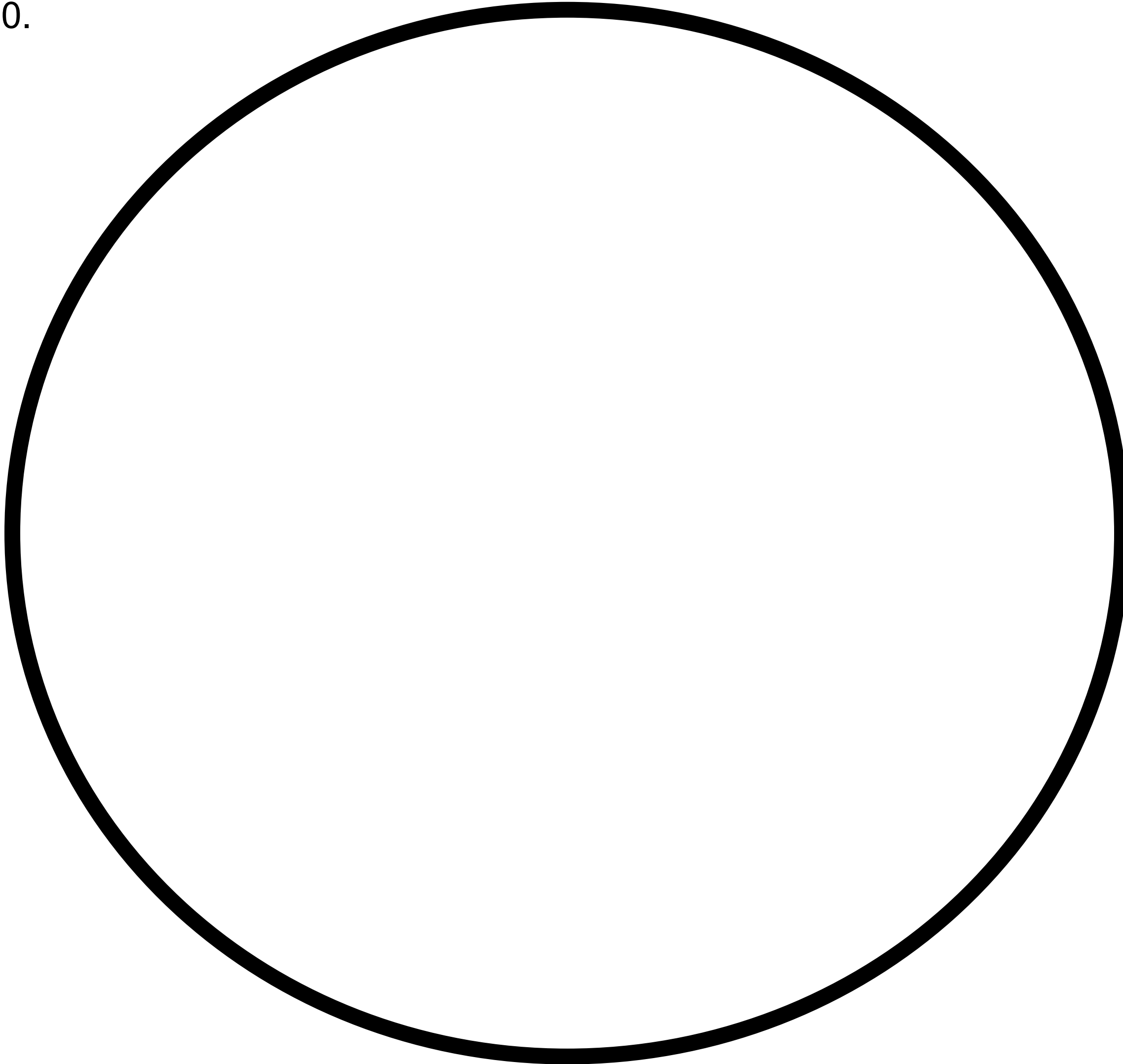
Annual Wellness Visit

The Medicare Annual Wellness Visit (AWV) is an opportunity to meet with your primary care provider and focus on important health screenings and preventions. This is not your typical exam or follow up, which focuses on new or chronic conditions and their treatments. It's a proactive discussion about 'big picture' issues regarding your health. The focus of an AWV is on preventive services which are proven to keep you well; or to catch potential medical conditions as early as possible. The AWV includes services such as: immunizations, on-site screenings, and referrals for screening services. Topics discussed that fall outside of the Medicare AWV guidelines may incur a copay or deductible charge, following the CMS (Medicare) coding rules.

This circle represents the face of a clock.

Please put the numbers on it so that it looks like a clock.

Please add the hands of the clock to indicate the time "twenty minutes after ten", or 10:20.



Name: ___________________________________ DOB: _____________________ DATE: ______________

Please complete this checklist before seeing your doctor. Your answers will help you receive the best health care possible.

1 - Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Little Interest or pleasure in doing things you normally enjoy				
Feeling down, depressed, or hopeless				

2 - Over the last 4 weeks, how much bodily pain have you generally had?

☐ No pain ☐ Very mild pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain

3 – Have you fallen 2 or more times in the past year?

☐ Yes ☐ No

4 – Are you afraid of falling?

☐ Yes ☐ No

5 – Are you a smoker?

☐ No ☐ Yes ☐ Yes, but I'd like to quit

6 – During the last 4 weeks, how many drinks of wine, beer, or other alcoholic beverages have you had?

☐ None ☐ 1 drink or less per week ☐ 2-5 per week ☐ 6-9 per week ☐ 10 or more

7 – Do you exercise for about 20 minutes or more 3 or more days per week?

☐ Yes, most of the time ☐ Yes, sometimes ☐ No, I usually do not exercise that much

8 – During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?

☐ Very heavy ☐ Heavy ☐ Moderate ☐ Light ☐ Very light

9 – Do you always fasten your seat belt when you are in a car?

☐ Yes, usually ☐ Yes, sometimes ☐ No

10 – Are you having difficulties driving your car?

☐ Yes, often ☐ Sometimes ☐ No ☐ Not applicable, I do not use a car

11 – During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous or lonely, 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, not at all

Name: ________________________________ DOB: ____________________ DATE: _____________

12 – How often, during the past 4 weeks, have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up					
Sexual problems					
Trouble eating well					
Teeth or dentures					
Problems using the telephone					
Tired or fatigued					

	Yes	No
13 – Can you get to places that are out of walking distance without help? (example: can you travel alone by bus, taxi, or drive your own car?)		
14 – Can you shop for groceries or clothes without help?		
15 – Can you prepare your own meals?		
16 – Can you do your own housework without help?		
17 – Can you handle your own money without help?		
18 – Do you need help eating, bathing, dressing, or getting around your home?		
19 – Have you been given any information to help you with hazards in your house that might hurt you?		
20 – Have you been given any information to help you with keeping track of your medications?		

21 – How confident are you that you can control and manage most of your health problems?

☐ Very confident ☐ Somewhat confident ☐ Not very confident ☐ I don't have health problems

22 – During the past 4 weeks, how would you rate your health in general?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Comprehensive Health Assessment:

Current Concerns (Reminder: if your concerns fall outside the Medicare wellness visit guidelines (reference pg. 1), it will lead to a separate evaluation which may not be covered 100% by Medicare. If so, you will receive a bill for the balance):
List any risky or unhealthy behaviors that could effect your health (ex: poor nutrition, oral health, dental care, familial behaviors that have an effect on your health, etc.)
Have you or a family member ever been diagnosed with a mental health/behavioral condition? (ex: stress/anxiety, depression, post-partum depression, ADD, ADHD, etc.)
Are there any outside factors to consider that may affect your health and well-being? (ex: poverty, homelessness, unemployment, lack of support system, etc.)

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Are there any reasons that you would not be able to follow through with a plan of care that you and your provider put together? (ex: financial difficulties, transportation issues, lack of health insurance, etc.)
What, if any, are some cultural, spiritual, or lifestyle beliefs that may impact the kind of healthcare you want to receive?
Currently, or in the past, have you or any family member had an addiction to alcohol, prescription medications, or illicit drugs?
What, if any, traditional health remedies do you use at home to improve your health?

Review of Systems:

Circle any symptoms you have had over the last 4 weeks or would like to discuss with the provider:

General	Fever Chills Sweats Weakness Fatigue Weight loss Weight gain
Cardiology	Irregular heartbeat Chest pain Passing out Leg swelling
Dermatology	Skin lesion Rash New/changing mole
Endocrinology	Excessive sweating Excessive urinating Excessive thirst Increased appetite Cold intolerance Heat intolerance
Gastroenterology	Abdominal pain Nausea Vomiting Diarrhea Constipation Blood in stool
Hematology	Swollen glands Easy bruising
Musculoskeletal	New/worsening joint pain Pain/cramping down the back of the leg New/worsening back pain Pain/cramping in lower leg
Neurology	Headache Dizziness Memory loss Numbness/tingling Unsteady/abnormal walking
Ophthalmology	Blurred vision Visual changes
Psychology	Depression Anxiety Sleep disturbances
Respiratory	Shortness of breath Wheezing Coughing up blood Persistent cough
Urology	Painful urinating Blood in urine Urinary incontinence
Genitourinary	Pelvic pain Breast pain Pain w/ Intercourse Frequent nighttime urinating Obstructive symptoms when urinating Abnormal bleeding Abnormal discharge