

MEDICARE ADVANTAGE ANNUAL WELLNESS QUESTIONNAIRE

Patient name: _____ Date of Birth: _____ Date of exam: _____

Physicians/Practitioners or Hospitals you have been to since your *last* visit

Name/Specialty	Name/Specialty
1. _____	3. _____
2. _____	4. _____

Do you use any tobacco products? Yes No If yes, what type? _____ How much? _____
 Do you drink alcohol? Yes No If yes, how much? _____
 Do you exercise? Yes No If yes, amount/type: _____
 Do you wear your seat belt? Yes No Do you wear sun protection? Yes No
 Do you live alone? Yes No Can you read and/or write? Yes No
 Do you have a caregiver or family support to assist with ADLs (activities of daily living)? Yes No
 Have you obtained a tattoo or received a blood transfusion prior to 1985? Yes No

Diet: Balanced Vegetarian Diabetic Low salt Low fat Low carb Other: _____

Please provide the *last* date if you had the following:

Flu vaccine: ___/___/___ COVID Vaccine: (1st) ___/___/___ (2nd) ___/___/___ Brand: _____
 Any additional vaccines since last visit: _____

Colonoscopy or Sigmoidoscopy: ___/___/___ Where? _____
 DEXA: ___/___/___ Where? _____ Eye Exam: ___/___/___ Where? _____
 Aorta Ultrasound: ___/___/___ Where? _____ HIV Screen: ___/___/___ Where? _____
 Hep C Screen: ___/___/___ Where? _____ Hearing Evaluation: ___/___/___ Where? _____
 Last Pap Smear: ___/___/___ Where? _____
 Last Mammogram: ___/___/___ Where? _____ Do you perform monthly self-breast exams? ___
 Do you have breast lumps/nipple discharge? _____

Sexual History

Do you have known risks for HIV or other Sexually Transmitted Infection? _____
 Are you sexually active?: ___ Yes ___ No If so, with: (circle all that apply) Men Women Both
 Have you had multiple sexual partners in the last 6 months? ___ Yes ___ No
 Do you use condoms? ___ Yes ___ No Do you use a Birth Control Method? _____

Do you have an Advance Directive or Power of Attorney? _____ Would you like information? _____

HEARING SCREENING:

		Yes	No
Do you have a problem hearing over the telephone?			
Do people complain that you turn the TV volume up too high?			
Do you have to strain to understand conversation?			
Do you have trouble hearing in a noisy background?			
Do you find yourself asking people to repeat themselves?			
TOTAL "Yes" responses (2 or more indicates the need for a referral)			

STEADI BALANCE/FALL SCREENING

	Yes	Sometimes	No
Do you feel unsteady when standing or walking			
Are you worried about falling?			
Have you fallen in the past year?			

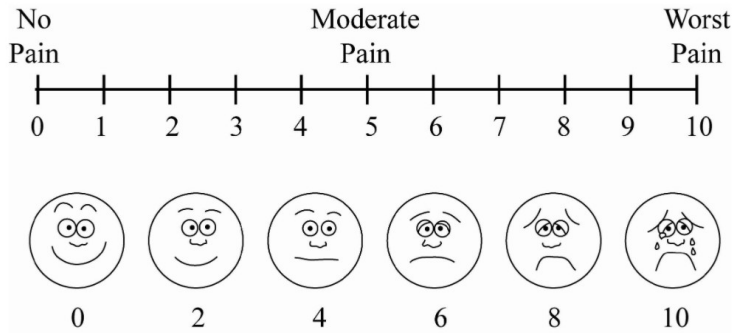
Patient Name: _____

Date of Birth: _____

Any pain present today? ___ Y ___ N

If "Y", where is your pain? _____

On a scale of 0 - 10, please rate your pain _____ (Use scale below as a guide)



How are you currently treating your pain? _____

Reviewed by: _____ **Staff Use Only** **Date:** _____

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