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) ___/___/___ (3rd) ___/___/___ 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? _____

Do you have problems with urine leakage/bladder control? _____

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)		

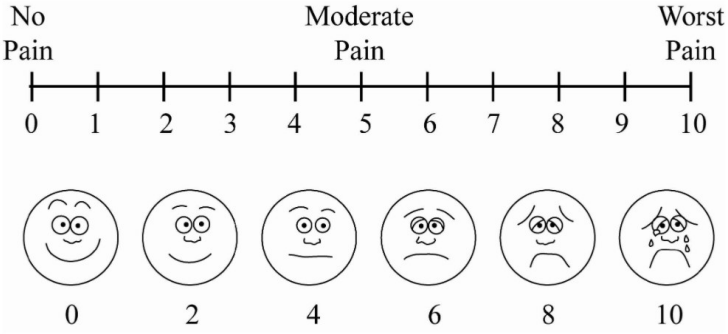
STEADI BALANCE/FALL SCREENING	Yes	Sometimes	No
Do you feel unsteady when standing or walking			
Are you worried about falling?			
Have you fallen in the past year?			

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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