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	Caner	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.

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