ANNUAL WELLNESS VISIT (AWV)

Please complete this checklist for your Medicare Wellness Visit (AWV). Your responses will assist us with providing you the best healthcare options.

Patient Name: ______________________ Today's Date:________________ Date of Birth: __________

Patient Age: _______ Gender (check one): Male_____ Female_____ Height ________________
Weight _________ Blood pressure ______/_______ BMI/waist circumference ________________

1. Have you been bothered by any emotional problems such as feeling anxious, depressed, irritable, sad, downhearted and blue? Check one from below:
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely
2. Has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely
3. How much bodily pain have you experienced lately?
   - ☐ No pain
   - ☐ Minimal pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain
4. Is there someone available to help you if you needed or wanted help?
   - ☐ Yes, as much and as often as I need
   - ☐ Yes, most of the time
   - ☐ Yes, but limited help available
   - ☐ Very little
   - ☐ No, not at all
5. What is the hardest physical activity that you can do for at least 2 minutes?
   - ☐ Very heavy physical activity
   - ☐ Heavy physical activity
   - ☐ Moderate physical activity
   - ☐ Light physical activity
   - ☐ I am unable to perform anything but very light physical activity
   - ☐ I am unable to perform any physical activity

6. Are you able to walk and get around on your own?
   - ☐ Yes ☐ No
7. Can you go out (e.g., shopping) on your own without anyone else's assistance?
   - ☐ Yes ☐ No
8. Can you prepare your own meals?
   - ☐ Yes ☐ No
9. Can you do chores and housework without anyone else's help?
   - ☐ Yes ☐ No ☐ Not applicable
10. Because of any health issues, do you need the help of another person with your personal care needs such as eating, bathing, dressing or getting around the house
    - ☐ Yes ☐ No
11. Can you handle your money and finances without any assistance from others?
    - ☐ Yes ☐ No
12. How would you rate your current general health?
    - ☐ Excellent
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor
13. How are things in your life going at this time?
    - ☐ Excellent, couldn't be better
    - ☐ Very good
    - ☐ Pretty good
    - ☐ Not bad
    - ☐ Pretty bad
    - ☐ Very bad
    - ☐ Awful, couldn't be worse
14. Are you having any difficulties driving your car?
    - ☐ Yes, often
    - ☐ Sometimes
    - ☐ No problems driving
    - ☐ Not applicable. I do not drive a car
15. Do you use a seatbelt when you drive or when you are in a car?
    - ☐ Yes, always
    - ☐ Yes, often
    - ☐ Only when driving or passenger in front seat
    - ☐ No, I do not wear a seatbelt

16. **Are you bothered with any of the following problems?**

PROBLEM	Never	Seldom	Occasionally	Often	Always
Falling down					
Sexual Problems					
Trouble eating healthy					
Teeth or denture issues					
Climbing stairs					
Tiredness / Fatigue					

17. **Have you fallen 2 or more times in the past year?**
    - ☐ Yes ☐ No
18. **Are you afraid of falling?**
    - ☐ Yes ☐ No
19. **Do you smoke cigarettes or use smokeless tobacco?**
    - ☐ No, I do not nor have I ever used any tobacco products
    - ☐ I currently am a smoker ______packs/day OR ______cigarettes/day
    - ☐ I used to be a smoker but quit (when?) ______________________
    - ☐ I would like to quit smoking
    - ☐ I am not interested in quitting smoking
    - ☐ I use smokeless tobacco (e.g., chew/snuff)
    - ☐ I used to use smokeless tobacco but quit (when?) ______________
20. **Do you use alcohol?**
    - ☐ Yes ☐ No
    - If yes, how much/how often
        - ☐ 10 or more drinks per week
        - ☐ 6-9 drinks per week
        - ☐ 2-5 drinks per week
        - ☐ 1 drink or less per week
        - ☐ I do not drink alcohol
21. **Do you exercise for 20 minutes or more?**
    - ☐ Yes ☐ No
    - If yes, how much/how often
        - ☐ Every day
        - ☐ 3 or more times per week
        - ☐ 1-2 times per week
        - ☐ I do not currently exercise
22. **Are there any hazards in your house that may be harmful?**
    - ☐ Yes ☐ No
23. **Are you able to keep track of your current medications?**
    - ☐ Not applicable. I do not currently take any prescription medications
    - ☐ I'm able to manage my medication regimen without any issues
    - ☐ I sometimes have trouble remembering to take my prescriptions medications
    - ☐ I am not always compliant with my prescription medication regimen
    - ☐ I am rarely compliant with my prescription medication regimen
    - ☐ I have a hard time remembering to take my medications and often forget

24. How confident are you managing your health problems yourself?
    - ☐ Very confident
    - ☐ Somewhat confident
    - ☐ Not very confident
    - ☐ I do not currently have health problems requiring monitoring
25. What's your ethnicity?
    - ☐ White ☐African American ☐Asian ☐Native American ☐Other ___________
    - ☐ I prefer not to answer

Please provide a list of all your healthcare providers:

Provider Name	Reason for Seeing This Provider	Seeing This Provider Currently?