Name_____Date of Birth_____Today's Date_____

Medicare Wellness Visit Patient Questionnaire

Advance Care Planning:

	Yes	No	Not Sure
Do you have an advance directive or living will?			
Do you have a healthcare proxy or surrogate decision maker			

Vitamins- check the ones you take Calcium_____ Multi-vitamin____ Vitamin D____ Other _____

Diet:

How many fruits and vegetables do you eat on most days? _____

How many fried foods do you eat on most days? _____

How many 8 oz. glasses of fruit juice or sweetened beverages do you drink on most days? _____

Home Safety:

	Yes	No
Do you have smoke detectors in your home?		
If you have firearms in your home, do you keep them unloaded and locked?		
Do you use a seat belt when in a vehicle?		

Functioning at Home:

	Able to	Not able to	Find It Difficult to
Feed yourself			
Toilet yourself			
Groom and dress yourself including socks and shoes			
Bathe yourself			
Handle your finances			
Obtain and take your medications properly			
Get into and out of a car			
Walk within your house without any issues			
Walk within your house, yard, and close proximities without issues			
Walk for exercise for at least 20 minutes without issues			
Go up and down stairs with no problems			
Kneel			
Do your own shopping			
Prepare your own food			
Do your own housekeeping			
Do your laundry			
Use a telephone			

Falls:

Did you fall in the year?	No	Yes
If yes, did your fall result in injury?		
Do you use a cane or walker?		
Do you have trouble with your balance?		

Health and Social Concerns:

	No	Yes
Do you, your family, or friends have concerns about your memory?		
Do you experience urinary incontinence?		
Do you have concerns about sex?		
Do you have problems with your teeth or gums?		
Do you have dentures?		
Do you see a dentist?		
Do you or anyone close to you have concerns about your hearing?		
Do you have concerns about handling your health or finances?		
Are you able to drive?		
Are you ever in a lot of pain?		
Do you feel isolated from others or feel abused in any way?		

PHQ – 2: Over the past 2 weeks, please indicate if you have been bothered by any of the following problems?

- Little interest or pleasure in doing things
- Feeling down, depressed, or hopeless

Substance Use:

Alcohol:

How many alcoholic drinks* do you have per week? Or I do not drink alcohol _____

_____ (*one drink = 12 ounces of beer, 5 ounces of wine or 1.5 ounces of 80 proof liquor)

On days when you drink alcohol, how often did you have (4 for men, 3 for women) alcoholic drinks on one occasion?

Circle one: Never / Occasionally / once per month / once or more per week

Do you ever drive after drinking, or ride with a driver who has been drinking? No Yes

Tobacco:

Do you use tobacco? Yes, I smoke _____ packs daily No Did in the past but I quit in _____ (year)

Do you vape or use electronic cigarettes? No Yes

Other Medications or Controlled Substances:

Do you take opioids (narcotics)? Yes No

Do you take drugs you obtained elsewhere? No Yes:_____

Medical and Family Hx Update:

Since your last visit, have you had any hospitalizations, surgeries, significant illnesses, or seen any new specialists? Yes No

Since your last physical, has anyone in your family (parents, children, siblings) had any new medical complications or death? Yes No

Thank you for participating in this wellness physical. Our goal is to keep you healthy! Newport Family Practice, P.C.