Medicare **Annual Wellness Visit**

**Name** ________________________________  
**Date of birth** ________________________________

*Circle your responses. Your answers will be kept confidential.*

### General health

<table>
<thead>
<tr>
<th>How would you rate your health compared to others your age?</th>
<th>Worse</th>
<th>Same</th>
<th>Better</th>
</tr>
</thead>
</table>

### Hearing and vision

1. Do you feel that a hearing difficulty limits your life?  
   - Yes  
   - No

2. Do you feel that a vision difficulty limits your life?  
   - Yes  
   - No

### Activities of daily living

1. Do you need help with dressing, eating, bathing, going to the bathroom, walking, or getting in or out of bed?  
   - Yes  
   - No

2. Do you need help with preparing meals, transportation, shopping, managing your finances, keeping house, making calls, or taking your medicine?  
   - Yes  
   - No

3. If you drive, have you had a car accident in the last year, or have you been asked to stop driving?  
   - Yes  
   - No  
   - I do not drive

4. Who do you live with?  
   - Alone  
   - Partner/spouse  
   - Child  
   - Parent  
   - Other:

5. Are you working or volunteering?  
   - Yes  
   - No

   *If you do, what do you do, and for how many hours a week?*

   | < 10 | 11-20 | 21+ |

### Home safety

| Does your home have throw rugs, poor lighting, a slippery bathtub or shower or other hazards? | Yes | No |

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Medicare **Annual Wellness Visit** HRA (English, June 2019)
## Fall risk (STEADI questions — Stopping Elderly Accidents, Deaths and Injuries)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you fallen in the past year?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. If you have fallen, how many times?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you feel unsteady when standing or walking?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3. Do you worry about falling?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

► If you answered yes to any of the above 3 questions, please also answer the following:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Do you use (or were you told to use) a cane or walker to get around safely?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Do you have to steady yourself by holding onto furniture when moving about your home?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6. Do you need to push with your hands to stand up from a chair?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you have trouble stepping up onto a curb?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8. Do you often have to rush to the toilet?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>9. Have you lost some of the feeling in your feet?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you take any medicine that makes you feel light-headed or tired?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Do you take medicine to help you sleep or improve your mood?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>12. Do you feel sad or depressed?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Continue here.

### Incontinence screening

Do you have trouble holding your bowels or bladder? | Yes | No |

### Advance care planning

Do you have an Advance Directive with designation of a Health Care Representative/Power of Attorney? | No | Yes | Not sure |
**Nutrition**

1. How is your appetite?  
   - Poor  
   - Fair  
   - Good

2. Have you lost weight without meaning to in the last year?  
   - Yes  
   - No

3. Do you eat two or more servings of fruits and vegetables every day?  
   - No  
   - Yes

**Exercise**

How many days a week do you exercise?

*If you exercise:*  
What do you do?  
For about how many minutes each time?

**Substances**

1. Do you smoke or chew tobacco?  
   *If you do,* how much and how often?  
   - Yes  
   - Not currently  
   - Never

2. Do you drink alcohol?  
   *If you drink alcohol,* how often and how much?
   
   - I drink...  
   - Monthly or less  
   - 2-4 times a month  
   - 2-3 times a week  
   - 4 or more times a week

   Standard drinks are 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of liquor each

   - 1-2  
   - 2-4  
   - 5-6  
   - 7-9  
   - 10+

   *drinks in a typical day when I’m drinking.*

3. Do you use any recreational drugs?  
   *If you’ve used anything in the last year, please list.*  
   - Yes  
   - Not currently  
   - Never

   Marijuana  
   Others: __________________
**Depression screening (PHQ-2/9)**

**Over the last 2 weeks,** how often have you been bothered by any of the following?  
*Please circle one response for each question.*

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have little interest or pleasure in doing things?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Do you feel down, depressed or hopeless?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**If the total score from the above questions is 3 or more,** please also answer the following:

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Do you have trouble falling asleep, staying asleep or are you sleeping too much?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Do you feel tired or have little energy?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Do you have poor appetite or overeating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Do you feel bad about yourself, or feel that you’re a failure or have let yourself or your family down?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Do you have trouble concentrating on things, such as reading or watching television?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Do you move or speak so slowly that other people have noticed? Or, the opposite — have you been so fidgety or restless that you have been moving around a lot more than usual?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Have you had thoughts that you would be better off dead, or of hurting yourself?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?</td>
<td>Not difficult at all</td>
<td>Very difficult</td>
<td>Somewhat difficult</td>
<td>Extremely difficult</td>
</tr>
</tbody>
</table>