Annual Wellness Visit (Medicare)

➔ NAME: Date of Birth:

Thank you for scheduling your Annual Wellness Visit, an important Medicare benefit. **Please help us meet Medicare requirements by filling out the survey which will become part of your medical record.**

How would you describe your **current health** status? (Circle one)

Excellent Very Good Good Fair Poor

Compared to one year ago, is your health: Better The same Worse

Are you having trouble with your **vision**? Yes No

Are you having trouble with your **hearing**? Yes No

Are you having **dental** problems? Yes No

Are you having trouble with your **memory**? Yes No

Are you having **pain**? Yes No

If you are having pain, where is it located? _____

Do you need help with any of the following activities? (**Circle all that require help**)

Dressing **Bathing** **Walking** **Feeding yourself**

Shopping **Housekeeping** **Using the toilet**

Managing your medication **Paying your bills**

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Do have functioning smoke detectors in your home? **Yes** **No**

Do you have grab bars in the bathroom? **Yes** **No**

Do you have throw rugs or extension cords? **Yes** **No**

Have you fallen in the past year? **Yes** **No**

Have you experienced a fall that caused injury? **Yes** **No**

Do you have **a healthcare proxy**? **Yes** **No**

If you have a **healthcare proxy**, have you made changes in the past year?

_____

We track the information below in your medical record. Please provide updates:

Vaccine review: **Flu shot** (*recommended in the fall*): DATE _____

Pneumonia vaccine (*age 65*): DATES _____

Tetanus vaccine (*every 10 years*): DATE _____

Shingles vaccine (*2 doses age 50+*): DATES _____

Cancer screening: **Mammogram**: DATE _____ Location _____

Colon cancer: DATE _____ Test_____

Please list your other doctors (including specialists you are seeing)

_____

_____

Please list **your current medications** on the back of this sheet or on another paper