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MEDICARE ANNUAL WELLNESS VISIT FORM

Name _____ Date_____

The Medicare Annual Wellness Visit ("AWV") is meant to review your health status, update preventive care measures, and develop a plan for your continued good health. Medicare allows this visit once every 12 months.

Do you have any specific health issues you want to address? If so, please specify:

Please list the names and specialty of all the other doctors that you see

You may use the back for additional names

Name	Specialty

Please list any over the counter medications you have taken

Please list the names, doses and instructions for ALL prescription medications that you have (even if they are only taken "as needed"). Use the back if needed.

Name_____ Date_____

Have you developed any other health issues since you were last seen? YES NO

If yes, please describe_____

_____

Have you fallen in the last year? YES NO If so, how many times_____

Do you feel unsteady walking? YES NO

Do you need an assistive device to walk (cane or walker)? YES NO

Do you have problems with urinary incontinence? YES NO

Do you have problems with bowel incontinence? YES NO

Have you seen an eye doctor in the last year? YES NO

Do you wear glasses or contacts? YES NO

Do you wear hearing aids? YES NO

Do you see a dentist at least once yearly? YES NO

Do you wear dentures? YES NO

Do you have an advanced directive (living will)? YES NO

If Yes, where is it located? _____

Do you feel you have memory problems? YES NO

Do family members worry about your memory? YES NO

Do you feel down, depressed, or hopeless? YES NO

Do you have little interest in doing things? YES NO

Do you live alone? YES NO

Do You Drive? YES NO

Have you been involved in a motor vehicle accident recently? YES NO

How many alcoholic drinks do you have per week_____ or per month_____?

Do you smoke? YES NO Did you ever smoke? YES NO

Name_____ Date_____

Vaccines	Date	Frequency
Tetanus (Tdap)	_____	Every 10 years
Pneumonia	_____	after age 65 (1 or 2 doses)
Shingles	_____	2 doses after age 50
Influenza	_____	yearly
COVID-19	_____	yearly
RSV	_____	once after age 60
Hepatitis B	_____	(optional, 3 doses)
Hepatitis A	_____	(optional, for travel)

Screenings	Date	Frequency
Mammogram (females)	_____	Yearly or every 2 years
Colon screening	_____	every 1-10 years
PSA (males)	_____	Yearly (age 55-69; optional)
EKG	_____	Diagnosis-dependent
Cholesterol	_____	Every 2 years
Bone Density (Female)	_____	Age 65 or every 2 years if low
Hepatitis C	_____	Once

REVIEW OF SYMPTOMS (Please **Circle** any symptoms you have experienced recently)

GENERAL: - weight gain - loss of appetite - fever - weakness - weight loss - night sweats

HEAD: - cold - cough - coughing blood - nose bleed - hearing loss - change in voice - sore throat
- ringing in ears - snoring

EYES: - diminished vision - eye irritation - drainage from eyes - blurred vision - allergic eyes - loss of vision

ENDOCRINE: - fatigue - excessive sweating - excessive thirst - excessive urination - weight loss
- cold intolerance - heat intolerance

ALLERGY: - runny nose - scratchy throat - itchy eyes - ear fullness - sinus congestion - stuffy nose

HEART: - chest pain - palpitations - leg swelling

LUNGS: - shortness of breath - pain with breathing - chest congestion

DIGESTIVE: - nausea - heartburn - stool incontinence - vomiting - bloating/belching - blood in stool
- difficulty swallowing - abdominal pain - diarrhea - constipation - change in bowel habits

URINARY: - difficulty urinating - blood in urine - urinary urgency - frequent urination - urinary incontinence
- genital pain - recurrent UTI - nighttime urination

SKIN: - rash - change in moles - lumps - dry/sensitive skin - hives

NERVOUS: - headache - tingling/numbness - seizures - insomnia - memory loss - dizziness - vertigo

BLOOD/GLANDS: - swollen glands - varicose veins - easy bruising

SKELETAL: - joint swelling - joint pain - muscle cramps - muscle pains - joint stiffness - trouble walking

PSYCHIATRIC: - high stress level - depression - sleep disturbances - overwhelming sense of panic
- suicidal thoughts - eating disorder - mental/physical abuse

MALE: - difficulty with erection - difficulty with ejaculation - diminished sexual drive - abnormal discharge

FEMALE: - heavy periods - pain with intercourse - premenstrual moodiness - pain with periods - infertility
- yeast infections - vaginal itching - bleeding between periods - irregular periods - abnormal discharge
- hot flashes - breast lumps - nipple discharge

Name_____ Date_____

Please review the following tasks and check off the box that best applies to you

	I can do on my own	I need help	I cannot do
Bathing			
Eating			
Dressing			
Using the toilet			
Getting out of or into bed or a chair			
Manage medications			
Use the Telephone			
Arrange transportation			
Prepare meals			
Shopping			
Perform Housework			
Manage finances			

Name_____ Date_____

Home Safety – Self-Assessment

Please indicate (yes or no) to the following safety item questions.

Are emergency numbers kept by the phone and regularly updated?	YES/NO
Do all household members know how to report an emergency?	YES/NO
Are all household members aware of the dangers of smoking, especially in bed?	YES/NO
Are firearms stored unloaded and securely locked?	YES/NO
Are all poisons (eg, medications, detergents, insecticides, cleaning agents, polishes) kept out of reach of children and those with impaired cognitive function and discarded when no longer needed?	YES/NO
Are working smoke alarm(s) and fire extinguisher(s) available for use?	YES/NO
Do all household members know how to use them?	YES/NO
Is there an escape plan in case of fire or other disaster?	YES/NO
Have throw rugs been removed or fastened down?	YES/NO
Are all electrical cords in working order, easily seen, and not run under rugs/carpets or wrapped around nails?	YES/NO
Are non-slip mats in all bathtubs and showers?	YES/NO
Do all stairways have a railing or banister?	YES/NO
Are doorways, halls, and stairs free of clutter and adequately lit?	YES/NO
Are sidewalks and all outdoor steps clear of tools, toys, and other articles?	YES/NO
Does all medical support equipment in use function properly?	YES/NO

Name_____ Date_____

Nutritional Assessment

	Yes	No	Score
I have an illness or condition that made me change the kind and/or amount of food I eat.			2
I eat fewer than 2 meals per day			3
I eat few fruits or vegetables or milk products.			2
I have 3 or more drinks of beer, liquor or wine almost every day.			2
I have tooth or mouth problems that make it hard for me to eat.			2
I don't always have enough money to buy the food I need.			4
I eat alone most of the time.			1
I take 3 or more different prescribed or over-the-counter drugs a day.			1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.			2
I am not always physically able to shop, cook and/or feed myself.			2