



HEALTHCARE CENTERS of MORRIS HOSPITAL

MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

Date: _____

Date of Birth: _____

Last Name: _____ First Name: _____ MI: _____

PROVIDERS INVOLVED IN YOUR HEALTHCARE

In an effort to ensure optimal care coordination, please list below all providers you see on a regular basis (examples: cardiologist, pulmonologist, endocrinologist, urologist, nephrologist, rheumatologist, neurologist, podiatrist, eye specialist, dentist, oxygen supplier, home health agency or other specialist)

Provider Name	Specialty

TOBACCO SCREENING

Tobacco Use: Never Current, Daily Smoker Current, Some Days Smoker Former Smoker
If current or former, what tobacco products do you use? Cigarettes Cigars Pipe
If current or former cigarette smoker, how many per day? # of packs per day _____ OR # of cigarettes per day _____
If current or former cigarette smoker, date/year started smoking _____
If former cigarette smoker, date/year quit smoking _____
If current or former cigarette smoker, number of years smoked _____
If former cigarette smoker, how long has it been since you smoked? less than 15 yrs ago more than 15 years ago
If current daily smoker, are you interested in quitting? Ready to Quit Thinking About Quitting Not Ready to Quit
 Do you use any of these nicotine products? E-Cigarettes Vaping Products Smokeless Tobacco Other: _____
If you use smokeless tobacco, what product?
 chewing tobacco Snuff snus dissolvable tobacco Other: _____
 Do you have exposure to second hand tobacco smoke? Yes No

ALCOHOL SCREENING

Did you have a drink containing alcohol in the past year? Yes No

If yes, how often did you have a drink containing alcohol in the past year?

monthly or less 2 to 4 times a month 2 to 3 times per week 4 or more times a week

If yes, how many drinks did you have on a typical day when you were drinking in the past year?

1 or 2 3 or 4 5 or 6 7 to 9 10 or more

If yes, how often did you have six or more drinks on one occasion in the past year?

never less than monthly monthly weekly daily or almost daily

DRUG SCREENING

Non-prescribed substance use:

- Denies use Former substance abuser Cannabis / any form Crack / cocaine
 Amphetamines / methamphetamines Sedatives / tranquilizers Opioids / painkillers
 Club / designer drugs Over the counter / e.g. Imodium Decline to answer Other

HEARING SCREEN

Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you sometimes feel that people are mumbling or not speaking clearly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you experience difficulty following dialogue in the theater or while watching TV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you find yourself asking people to speak up or repeat themselves?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you sometimes have difficulty understanding speech on the telephone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you experience ringing or noises in your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you hear better with one ear than the other?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FUNCTION SCREEN

Do you need helping feeding yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help getting from bed to chair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help getting to the toilet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help getting dressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help bathing or showering?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help walking across the room (includes using cane or walker)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help using the telephone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help taking your medicines?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help preparing meals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you need help managing money (like keeping track of expenses or paying bills)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help shopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help with transportation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help climbing a flight of stairs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HOME SAFETY SCREEN		
Do you have easy access to a phone at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are emergency numbers easily accessible?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have functioning smoke/carbon monoxide alarms in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have non-slip surface and grab bars in bath/shower?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you climb stairs at home, are there secure railing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>*Office Use: Enter Mini-Cog Score in EMR</i>		

NUTRITION		
Are you following a diet by a prescribed by a doctor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you following a special diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ADVANCE CARE PLANNING		
Do you wish to discuss your end-of-life medical treatment decisions and/or who you designate to make decisions for you if you are unable to speak for yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FALL RISK ASSESSMENT		
Have you experienced any balance or walking problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you fallen at all in the past year?	<input type="checkbox"/> No prior history of falls <input type="checkbox"/> 1 fall in the past year <input type="checkbox"/> 2+ falls in the past year <input type="checkbox"/> Fall with injury in the past year <input type="checkbox"/> Bedridden <input type="checkbox"/> Other: _____	
If yes, were you injured?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Assistive device used:		
<input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Commode chair <input type="checkbox"/> Hospital Bed <input type="checkbox"/> Respiratory device		

EXERCISE		
On many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?		
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		
Duration: On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise? _____ minutes		

DEPRESSION SCREENING (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle your answer to each question)	Not at all	Several days	More than half the days	Nearly Every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself --- or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite --- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

= Total Score: _____

If you checked off any problems, 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?

Not difficult
at all

Somewhat
difficult

Very
difficult

Extremely
difficult