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?	☐ Yes	☐ No
Do you sometimes feel that people are mumbling or not speaking clearly?	☐ Yes	☐ No
Do you experience difficulty following dialogue in the theater or while watching TV?	☐ Yes	☐ No
Do you find yourself asking people to speak up or repeat themselves?	☐ Yes	☐ No
Do you sometimes have difficulty understanding speech on the telephone?	☐ Yes	☐ No
Do you experience ringing or noises in your ears?	☐ Yes	☐ No
Do you hear better with one ear than the other?	☐ Yes	☐ No

FUNCTION SCREEN

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

Do you need help managing money (like keeping track of expenses or paying bills)?	☐ Yes	☐ No
Do you need help shopping?	☐ Yes	☐ No
Do you need help with transportation?	☐ Yes	☐ No
Do you need help climbing a flight of stairs?	☐ Yes	☐ No

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

NUTRITION
Are you following a diet by a prescribed by a doctor? ☐ Yes ☐ No
Are you following a special diet? ☐ Yes ☐ 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?	☐ Yes	☐ No

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

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