Medicare Annual Wellness Visit (AWV)

****Please fill out the first 2 pages of this packet**

Date: _____ Date of Birth: _____

Last Name: _____ First Name: _____ MI: _____

Health Risk Assessment

General Health		
In the past 4 weeks rates general health ___Good ___Fair ___Poor		
Do you report things are getting _____ Better ____Same _____Worse		
Do you report having ___No trouble taking meds as prescribed _ ___Trouble taking meds as prescribed ___Affording meds prescribed		
How many days a week does physical pain affect your daily activities? ____0 ____1-2 ____3-4 ____≥5		
If greater than 3 days, do you have a management plan for pain? analgesics _____ heat____ massage____ PT____ exercise____ other_____		
Do you visit your dentist for regular check-ups at least every six months if you have natural teeth, or once a year if you have full dentures?	**YES**	**NO**
How is the health of your mouth and teeth? ___Excellent ___Good ___Fair ___Poor ___I don't know		

Nutrition	**YES**	**NO**
Do you have a good breakfast ___0 days/week ____1-3 days/week ___4 or more days/week		
Number of sweetened drinks a day ___ 1-2 ___3 or more ___ 0		
Number of servings of fruits and vegetables you have in a day? ___1-3 ___4-7 ___8-10 ___>10 ___NONE		
Do you eat with family and friends ____none ___1-3 ___4 or more days a week		

Exercise
_____Do you exercise about 20 minutes 3 or more days a week
_____Does not exercise 20 minutes 3 or more days a week
Activity level is
_____Light ____Moderate ____Heavy

Education
What is your level of education _____

Sleep
How many hours of sleep do you get in a day _____
Gets out of bed at _____
Patient _____ Naps during the day _____Doesn't nap during the day General length of nap _____

PHQ-9 Depression Screening 0-not at all 1-Several Days 2-More than half the days 3-Nearly everyday	
1. Little interest or pleasures in doing things	
2. Feeling down, depressed or hopeless	
3. Trouble falling or staying asleep, or sleeping too much	
4. Feeling tired or having little energy	
5. Poor appetite or overeating	
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	
7. Trouble concentrating on things, such as reading the newspaper or watching television	
8. 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	
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	
TOTAL	

Annual Alcohol Screening	YES	NO
Did you have a drink containing alcohol in the past year?		
If yes, how often did you have a drink containing alcohol in the past year? ___monthly or less ___2-4 times a month ___2-3 times per week ___4 or more times per 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		

Tobacco Screening	YES	NO
Are you a ___? ____non-smoker ____former smoker ____current daily smoker ____current some day smoker ____chew tobacco user		
If a former smoker, how long has it been since you last smoked? ___<1 month ___1-3 months ___4-6 months ___7-12 months ___1-5 years ___5-10 years ___>10 years		
If current daily smoker, how many cigarettes a day do you smoke? ___5 or less ___6-10 ___11-20 ___21-30 ___31 or more		
If current daily smoker, how soon after you wake up do you smoke? ___within 5 min ___6-30 min ___31-60 min ___after 60 min		
If current daily smoker, are you interested in quitting? ___ready to quit ___thinking about quitting ___not ready to quit		

Opioid Prescription Review Substance Use Disorder Screening	YES	NO
Do you currently use opioid prescription medications for chronic or acute pain? Examples: hydrocodone, oxycodone, fentanyl patches, morphine etc		

Substance Use Disorder Screening: NIDA Quick Screen					
In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					
Screening Results:					

Functional Ability and Safety

Home Safety	YES	NO
Do you have access to a phone at home?		
Are emergency numbers easily accessible?		
Do you have functioning smoke/carbon monoxide alarms in your home?		
If you climb stairs at home, is there secure railing?		
Hearing Screen		
Do you use hearing aids or other devices to help you hear?		
Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?		
Do you sometimes feel that people are mumbling or not speaking clearly?		
Do you experience difficulty following dialogue in the theatre or while watching TV?		
D . ou find yourself asking people to speak up or repeat themselves?		
Do you sometimes have difficulty understanding speech on the telephone?		
Do you experience ringing or noises in your ears?		
Do you hear better with one ear than the other?		
Fall Risk Assessment		
Do you feel dizzy when you stand up?		
Have you fallen in the past year?		
If yes, how many times?	__1	__>2
Were you injured?		
Do you need help climbing a flight of stairs? In public? At home?		
Do you have non-slip surfaces and grab bars in bath/shower?		
Do you need any devices to assist you with walking or bathing (ex; cane, walker, shower chair?)		
ADLs		
Do you need help feeding yourself?		
Do you need help getting from the bed or chair?		
Do you need help getting to the toilet?		
Do you need help getting dressed?		
Do you need help bathing or showering?		
Do you need help using the telephone?		
Do you need help taking your medicines OR need reminders?		
Does anyone assist you with preparing meals?		
Does anyone assist you with managing money (like keeping track of expenses or paying bills?)		
Does anyone assist you with shopping?		
Do you need help with transportation?		
Do you find it difficult to drive or operate a vehicle? Driving at night?		

Urinary Health
Many people experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experienced leakage of urine?
Leaks Urine: _____ with coughing or sneezing _____ when bends or lifts _____with jogging, walking quickly _____while undressing to use the toilet _____before gets to toilet when has strong urge _____has to rush to the bathroom because gets a strong sudden urge to urinate
_____Stress Incontinence _____Urge Incontinence _____No further eval needed

Advanced Care Planning	YES	NO
Have you discussed your end of life wishes with your provider? Examples: DNR, Advanced Directive, Living will		
If yes, does your provider have a copy of your wishes on file?		
Would you like more information?		

PROVIDERS INVOLVED IN YOUR HEALTHCARE:
In an effort to ensure optimal care coordination, please list below all providers you see on a regular basis.

Specialty	Provider
Cardiologist	
Pulmonologist	
Eye Doctor	
Endocrinologist	
Gynecologist	
Dermatologist	
Ear, nose, and throat	
Physical Therapist	
Other:	

Any changes in your medications since your last visit? Including supplements, over the counter items, vitamins, eye drops, inhalers, topicals and nasal sprays.

_____

_____

_____

_____

*Depending on your insurance, today's yearly wellness visit may include but is not limited to a comprehensive physical exam, eye exam, preventive health work up and lab work if warranted.

On behalf of Abingdon Internal Medicine, thank you for entrusting us with your care.