



DATE OF VISIT: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

**MEDICARE ANNUAL WELLNESS VISIT SELF-ASSESSMENT FORM**

**Please answer the following questions based upon how you have been doing in the past four weeks.** Your answers will help us identify areas to address and provide you with the best possible healthcare.

- |    |   |  |                                   |  |
|----|---|--|-----------------------------------|--|
| 1. | How does your physical health compare to last year?   | <input type="checkbox"/> Worse   | <input type="checkbox"/> Same     | <input type="checkbox"/> Better        |
| 2. | How does your emotional health compare to last year?  | <input type="checkbox"/> Worse   | <input type="checkbox"/> Same     | <input type="checkbox"/> Better        |
| 3. | Has your physical or emotional health limited your activities with family, friends, neighbors, or groups?             | <input type="checkbox"/><br>Most of the time   | <input type="checkbox"/><br>Often | <input type="checkbox"/><br>Not at all |
| 4. | On a scale of 0 (no pain) to 10 (most severe pain imaginable), what level of pain do you experience on a daily basis? | <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 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 |                                   |  |

**Activities of Daily Living**

- |     |  |                              |                             |
|-----|--|------------------------------|-----------------------------|
| 5.  | Can you travel independently by bus, taxi/ride-share (e.g. Uber), or drive your own car? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6.  | Can you do your own housekeeping without help?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7.  | Can you prepare your own meals?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8.  | Can you handle your own money without help?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9.  | Do you have hearing issues or require a hearing aid?                                     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. | Do you need glasses or contacts for routine vision?                                      | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. | Do you have any difficulty with eating or meal preparation?                              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 12. | Do you have any difficulty with bathing or grooming?                                     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

**Fall Risks**

- |     |  |  |                             |
|-----|--|--|-----------------------------|
| 13. | Have you fallen two or more times in the past year?            | <input type="checkbox"/> YES   | <input type="checkbox"/> NO |
| 14. | Are you afraid you will fall?                                  | <input type="checkbox"/> YES   | <input type="checkbox"/> NO |
| 15. | Have you been bothered recently by dizziness when standing up? | <input type="checkbox"/> YES   | <input type="checkbox"/> NO |
| 16. | How do you move around?  | <input type="checkbox"/> Independently <input type="checkbox"/> I am unsteady<br><input type="checkbox"/> With a cane or walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bed-bound |                             |

**Lifestyle/Behavior**

17. How many times do you exercise per week?  Never  1-2  2-3  4+
- 
18. Have you leaked urine in the past 6 months?  YES  NO
- 
19. In the past 2 weeks, did you miss any doses of your medicines?  YES  NO
- 
20. How often do you miss doses of your medicines?  Never  A few times a year  
 A few times a month  A few times a week  Frequently
- 
21. Which factors keep you from taking your medicine as directed?  
 Forgetfulness  Side Effects  Cost  
 Do not understand the directions  Do not think it is necessary  
 Do not think it helps  Other:
- 
22. Do you currently smoke cigarettes or use tobacco products?  YES  NO
- 
23. If you have ever used tobacco products, in what year did you start? \_\_\_\_\_  
 If you smoked, how many packs per day did you use? \_\_\_\_\_  
 If you quit using tobacco, in what year did you quit? \_\_\_\_\_

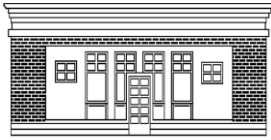
**Resources**

24. Do you have an advance directive or living will?  YES  NO
- 
25. Would you have someone to help you if you were ill and needed help with chores, emotional support or companionship, or care in your home?  
 Yes, as much help as I need  Yes, some help  No, I have no one who can help me
- 
26. How confident are you that you can control and manage most of your health problems?  
 Very Confident  Somewhat confident  Not very confident  I have no health problems
- 
27. Do you have any social or financial concerns?  YES  NO

**Satisfaction with Access**

28. Are you satisfied with your access to appointments at our office?  YES  NO
- 
29. Are you satisfied with the care or treatment you receive here?  YES  NO
- 
30. Are there barriers to receiving care that you would like addressed?  YES  NO

Provider (printed): \_\_\_\_\_ Provider Signature: \_\_\_\_\_



DATE OF VISIT: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

**PATIENT HEALTH QUESTIONNAIRE 9 (PHQ-9)**

Over the past 2 weeks, how often have you been bothered by any of the following problems?		Not At All	Several Days	More than Half the Days	Nearly Every Day
1.	Little interest or pleasure in doing things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2.	Feeling down, depressed or hopeless.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3.	Trouble falling asleep, staying asleep, or sleeping too much.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4.	Feeling tired or having little energy.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5.	Poor appetite or overeating.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6.	Feeling bad about yourself, or that you're a failure or have let yourself & your family down.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7.	Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9.	Thoughts that you would be better off dead, or of hurting yourself in some way.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
		Column Totals:			
		Add Column Totals Together:			

**If you checked off any problems above...**

10. How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

- Not At All     Somewhat Difficult     Very Difficult     Extremely Difficult

© 1999 Pfizer Inc. (PHQ-9)

11. How often do you have a drink containing alcohol?

- Never     Monthly or less     2-4 times per month     2-3 times per week     4+ times per week

12. How many standard drinks containing alcohol do you have on a typical day?

- 0, 1, or 2     3 or 4     5 or 6     7 to 9     10 or more

13. How often do you have six or more drinks on one occasion?

- Never     Less than monthly     Monthly     Weekly     Daily or almost daily

AUDIT-C is available for use in the public domain.

Provider (printed): \_\_\_\_\_

Provider Signature: \_\_\_\_\_