Medicare Annual Wellness Visit Questionnaire

Patient's Name: _____ Date: _____
Date of Birth: _____ Current/former Occupation: _____
Drug Allergies: _____
_____
Please list any other physicians (Specialists) you see: _____
_____
Please list any surgeries you have had including dates: _____
_____

Have you had any of the following health problems? **Circle all that apply.**

Heart Attack	Tuberculosis (TB)	Back Problems	Kidney Infections	Arthritis
Heart Disease	Pneumonia	Diabetes	AIDS/HIV	Cystic Fibrosis
Heart Murmur	Stroke	Hypoglycemia	Thyroid Problems	**Down's Syndrome**
Chest Pain	Seizures	Hepatitis	Sinus Disease	**Cancer, type: _____**
High blood pressure	Head Injury	Jaundice	Hearing Loss	**None of the above**
Asthma	Migraines	Bleeding Disorder	Reflux Disease	**Other: _____**
Emphysema	Meningitis	Anemia	Ulcers	_____

Have any of your family members had the following health problems? **Circle all that apply.**

Heart Disease	Stroke	Hepatitis	Thyroid Problems	None listed
High blood pressure	Migraines	Bleeding Disorder	Hearing Loss	**Cancer, type: _____**
Tuberculosis (TB)	Arthritis/ Joint pain	Reflux Disease	AIDS/HIV	**Other: _____**
Asthma	Diabetes	Ulcers		_____

Have you had any of the following in the last month?

General	**Throat**	**Musculoskeletal**	**Gastroenterology**	**Neuro/ Psych**
Fever	Recent voice changes	Joint/back pain	Blood in stool	Numbness/ weakness
Weight loss	Difficulty breathing	Muscle weakness	Heartburn	Tingling
Weight gain	Difficulty swallowing	**Cardiology**	Abdominal pain	Depression
Night sweats	Can't clear throat	Chest pain	Constipation/Diarrhea	
Ears	Chronic cough	Shortness of breath	Nausea/Vomiting	**Hematology/ Endo**
Hearing Loss	Hoarseness	Swollen Ankles		Anemia
Ringing in ears	Sore throat	Heart palpitations	**Genital/Urinary**	Bleeding tendency
Ear Pain	Loss of taste		**Blood in urine**	Heat/ Cold intolerance
Ear Drainage	**Skin**	**Pulmonology**	**Painful urination**	High Blood Sugar
Ear fullness	Pigment changes	Coughing	**Frequent urination**	
Dizziness	Skin lesions	Wheezing		

Please answer yes or no to the following questions regarding your health

Over the last two weeks, have you felt down, depressed or hopeless?	**No**	**Yes**
Over the last two weeks, have you felt little interest or pleasure in doing things?	**No**	**Yes**
Do you have trouble hearing the television or radio when others do not?	**No**	**Yes**
Do you have to strain or struggle to hear/understand conversations?	**No**	**Yes**
Do you need help with preparing meals, transportation, shopping, taking you medicine, managing your finances, or other activities of daily living?	**No**	**Yes**
Do you live alone? If no, who lives with you?	**No**	**Yes**
Does your home have throw rugs, poor lighting, or a slippery bathtub/shower?	**No**	**Yes**
Does your home LACK grab bars in bathrooms, handrails on stairs and steps?	**No**	**Yes**
Does your home LACK functioning smoke alarms?	**No**	**Yes**
Have you ever smoked? If yes, # packs/day: # of years: If quit, when:	**No**	**Yes**
Do you drink alcohol? If yes, # drinks/day: # drinks/week:	**No**	**Yes**
Do you use recreational drugs? If yes, what type:	**No**	**Yes**
Are you on a special diet? If yes, what type:	**No**	**Yes**

_____ _____

Patient Signature **Date**

Annual Physical Exam Acknowledgement

An ***Annual Physical Exam*** is a "wellness" exam designed to provide a comprehensive physical examination in order to screen for disease, promote a healthy lifestyle, and assess a member's potential risk factors for future medical problems.

The Annual Physical Exam includes (based on CMS guidelines):

1. Health History Review
2. Vital signs
3. General appearance
4. Heart exam
5. Lung exam
6. Head and neck exam
7. Abdominal exam
8. Neurological exam
9. Dermatological exam
10. Extremities exam
11. Male physical exam

- Testicular, hernia, penis, and prostate exams

12. Female physical exam

- Breast and pelvic exams

13. Counseling to include healthy behaviors and screening services

Any health issues/problems not listed above are **NOT** considered part of a physical examination!

If you discuss other health concerns and or management of any health concern during your Physical Exam, **an office visit will be charged in addition to your physical and may generate a co-payment as a result.**

Because we care and want to provide you with the most efficient visit as possible, we will not ask you to make another appointment to discuss or manage your health concerns but please understand we are **legally obligated** to assign procedure codes based on the **service provided** to you.

We cannot change the coding later to cause the insurance company to pay for a non-covered service. If both services are billed you may be responsible for paying a co-payment for each service, depending on your insurance coverage.

By signing below, you have read and acknowledge the information stated above.

_____ _____

Patient signature Date

_____

Printed Patient Name