**Raleigh Family Practice, PA**

**Medicare Annual Wellness Visit**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CH# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please tell us about other doctors or healthcare providers who may be taking care of you**

|  |  |
| --- | --- |
| Health Care Provider | Why do you see this provider  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Please answer the following questions:**

**Cognitive**

Are you worried about your memory: Yes\_\_\_\_\_ No \_\_\_\_\_

How often has confusion or memory loss interfered with your ability to work, volunteer or engage in social activities?

Always \_\_\_\_\_ Usually \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_ Never \_\_\_\_\_

During the past 30 days how often has a family member or friend provided care or assistance for you because of confusion or memory loss?

Always \_\_\_\_\_ Usually \_\_\_\_\_ Sometimes \_\_\_\_\_ Rarely \_\_\_\_\_ Never \_\_\_\_\_

**Functional Status**

Do you have difficulty getting out of a chair or car without assistance? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you use a cane or walker? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any trouble hearing? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you have problems with vision? Yes \_\_\_\_\_ No \_\_\_\_\_

**Falls Risk Screening**

In the last 12 months have you fallen? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many times? \_\_\_\_\_\_\_

Were you injured as a result of a fall? Yes \_\_\_\_\_ No \_\_\_\_\_

**Tobacco Use**

Do you currently use tobacco products? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much tobacco per day do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been using tobacco products? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you willing to quit? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you used tobacco products in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

**Depression Screening**

Over the past 2 weeks, have you been bothered by the following problems?

Little interest or pleasure in doing things: Yes\_\_\_\_\_ No \_\_\_\_\_ Feeling down, depressed or hopeless: Yes \_\_\_\_\_ No \_\_\_\_\_

**Do you have a living will? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please bring a copy with you for your medical records. If you would like to create one, please ask our staff for available resources.**