

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.