Name:_____Today's Date:_____Date of Birth_____

ATLANTA CENTER FOR MEDICINE
MEDICARE ANNUAL WELLNESS QUESTIONNAIRE

Please complete this checklist before seeing your doctor or nurse. Your answers will help us to deliver the best healthcare possible.

1. What is your age?
   ☐ 65-69 ☐ 70-79 ☐ 80 or older

2. Are you a male or a female?
   ☐ Male ☐ Female

3. During the **past four weeks** how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?
   ☐ Not at all.
   ☐ Slightly.
   ☐ Moderately.
   ☐ Quite a bit.
   ☐ Extremely.

4. During the **past four weeks,** has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
   ☐ Not at all.
   ☐ Slightly.
   ☐ Moderately.
   ☐ Quite a bit.
   ☐ Extremely.

5. During the **past four weeks,** how much bodily pain have you generally had?
   ☐ No pain.
   ☐ Very mild pain.
   ☐ Mild pain.
   ☐ Moderate pain.
   ☐ Severe pain.

6. During the **past four weeks**, was someone available to help you if you needed and wanted help?
For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)
   ☐ Yes, as much as I wanted.
   ☐ Yes, quite a bit.
   ☐ Yes, some.
   ☐ Yes, a little.
   ☐ No, not at all.

7. During the **past four weeks,** what was the hardest physical activity you could do for at least two minutes?
   ☐ Very heavy.
   ☐ Heavy.
   ☐ Moderate.
   ☐ Light.
   ☐ Very light.

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or in taxis, or drive your own car?)
   ☐ Yes ☐ No

9. Can you go shopping for groceries or clothes without someone's help?
   ☐ Yes ☐ No

10. Can you prepare your own meals?
   ☐ Yes ☐ No

11. Can you do housework without help?
   ☐ Yes ☐ No

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
   ☐ Yes ☐ No

13. Can you handle your own money without help?
   ☐ Yes ☐ No

14. During the **past four weeks,** how would you rate your health in general?
   ☐ Excellent.
   ☐ Very good.
   ☐ Good.
   ☐ Fair.
   ☐ Poor.

15. How have things been going for you during the **past four weeks?**
   ☐ Very well; could hardly be better.
   ☐ Pretty well.
   ☐ Good and bad parts about equal.
   ☐ Pretty bad.
   ☐ Very bad; could hardly be worse.

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16. Are you having difficulties driving your car?
- ☐ Yes, often.
- ☐ Sometimes.
- ☐ No.
- ☐ Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?
- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

18. How often during the **past four weeks** have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.	☐	☐	☐	☐	☐
Sexual problems.	☐	☐	☐	☐	☐
Trouble eating well.	☐	☐	☐	☐	☐
Teeth or denture problems.	☐	☐	☐	☐	☐
Tiredness or fatigue.	☐	☐	☐	☐	☐

19. Have you fallen two or more times in the past year?
☐ Yes ☐ No

20. Are you afraid of falling?
☐ Yes ☐ No

21. Are you a smoker?
- ☐ No.
- ☐ Yes, but I might quit.
- ☐ Yes, and I'm not ready to quit.

22. During the **past four weeks,** how many drinks of wine, beer or other alcoholic beverages did you have?
- ☐ 10 or more drinks per week.
- ☐ 6-9 drinks per week.
- ☐ 2-5 drinks per week.
- ☐ One drink or less per week.
- ☐ No alcohol at all.

23. Do you exercise for about 20 minutes, three or more times per week?
- ☐ Yes, most of the time.
- ☐ Yes, some of the time.
- ☐ No, I usually don't exercise this much.

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?
☐ Yes ☐ No

Keeping track of your medications?
☐ Yes ☐ No

25. How often do you have trouble taking medicines the way you've been told to take them?
- ☐ I do not have to take medicine.
- ☐ I always take them as prescribed.
- ☐ Sometimes I take them as prescribed.
- ☐ I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?
- ☐ Very confident.
- ☐ Somewhat confident.
- ☐ Not very confident.
- ☐ I do not have any health problems.

27. What is your race? **(Check all that apply.)**
- ☐ White.
- ☐ Black or African American.
- ☐ Asian.
- ☐ Native Hawaiian
- ☐ Other Pacific Islander.
- ☐ American Indian or Alaskan Native.
- ☐ Hispanic or Latino origin or descent.
- ☐ Other.

Thank you very much for completing your **Medicare Annual Wellness Questionnaire**. Please bring your completed questionnaire with you to your Annual Wellness Visit, and give it to your doctor or nurse.