

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? Worse Same Better

- 2. How does your emotional health compare to last year? Worse Same Better

- 3. Has your physical or emotional health limited your activities with family, friends, neighbors, or groups? Most of the time Often 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?
 0 1 2 3 4 5 6 7 8 9 10

Activities of Daily Living

- 5. Can you travel independently by bus, taxi/ride-share (e.g. Uber), or drive your own car? YES NO

- 6. Can you do your own housekeeping without help? YES NO

- 7. Can you prepare your own meals? YES NO

- 8. Can you handle your own money without help? YES NO

- 9. Do you have hearing issues or require a hearing aid? YES NO

- 10. Do you need glasses or contacts for routine vision? YES NO

- 11. Do you have any difficulty with eating or meal preparation? YES NO

- 12. Do you have any difficulty with bathing or grooming? YES NO

Fall Risks

- 13. Have you fallen two or more times in the past year? YES NO

- 14. Are you afraid you will fall? YES NO

- 15. Have you been bothered recently by dizziness when standing up? YES NO

- 16. How do you move around? Independently I am unsteady
 With a cane or walker Wheelchair 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? _____

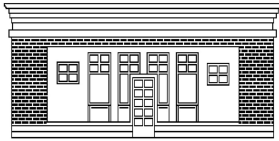
Resources

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: _____



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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

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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

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