ADVANCED INTERNAL MEDICINE
OF NORTHERN ILLINOIS

Medicare Annual Wellness Visit

Patient Name: _____ DOB: _____

Please list other physicians or health care providers involved in your health care? Name/Specialty:

_____ _____ _____

_____ _____ _____

What company provides your medical supplies? (Diabetes supplies, respiratory supplies, other)

_____ _____ _____

Are you experiencing any difficulties with any of the following (please circle)?

Bathing	Dressing	Toileting	Grooming	Feeding
Mobility	Taking Medications	Grocery Shopping	Preparing Meals	Using Telephone
Transportation	Managing your finances	Housekeeping	Laundry	Memory
Feeling unsteady	Falling down			

Please mark any of the items you have in your home:

Throw rugs	Yes	No	Smoke detectors	Yes	No
Stairs or steps without handrails	Yes	No	Bathroom handrails	Yes	No

During the past month, have you often been bothered by feeling down, depressed, or hopeless? No Yes

During the past month, have you often been bothered by little interest or pleasure in doing things? No Yes

How many days a week do you usually exercise? (circle) 1 2 3 4 5 6 Everyday Every other day

How much time do you spend exercising during these sessions?

☐ Less than 10 minutes ☐ 10-20 minutes ☐ 20-30 minutes

☐ 30-59 minutes ☐ 1 hour or more ☐ None, do not exercise

How intense is your typical exercise?

☐ Light (stretching or slow walking) ☐ Moderate (brisk walking) ☐ Heavy (jogging/swimming)

In a typical week, how many days do you drink alcohol?

☐ None ☐ 1 day ☐ 2-3 days ☐ 3-4 days ☐ 5-6 days ☐ Everyday

On days you drink alcohol, how many alcoholic drinks do you consume? (circle) 1 2 3 4 5 or more

In a typical week, how often do you have 5 or more alcoholic drinks on one occasion?

☐ Never ☐ Once a week ☐ 2-3 times/ week ☐ More than 3 times /week

Do you protect yourself from the sun when outdoors? Yes No

On a typical day, how many servings of fruits/and or vegetables do you eat?

☐ None ☐ Unsure ☐ 1 to 2 servings ☐ 3 to 4 servings ☐ 5 or more servings

On a typical day, how many servings of high fiber or whole grain foods do you eat?

☐ None ☐ Unsure ☐ 1 to 2 servings ☐ 3 to 4 servings ☐ 5 or more servings

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Patient Name:_____

On a typical day, how many servings of fried or high-fat foods do you eat?

☐ None ☐ Unsure ☐ 1 to 2 servings ☐ 3 to 4 servings ☐ 5 or more servings

Do you always fasten your seat belt when in a car? Yes No

Do you ever drive after drinking or ride with a driver who has been drinking? Yes No

In general, how satisfied are you with your life?

☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

How often is stress a problem for you?

☐ Never/rarely ☐ Sometimes ☐ Often ☐ Always

How well do you handle the stress in your life?

☐ I'm usually able to cope effectively ☐ At times I have problems coping ☐ I often have problems coping

In general, would you say your health is

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Do you have any oral health concerns? Yes No _____

Do you have any sexual health concerns? Yes No _____

Do you have any pain issues that you would like to discuss? Yes No _____

Patient Sign/Date: _____ **Provider** Sign/Date: _____

FOR THE MEDICAL PROVIDER

PROVIDER

- Medical and Family History
- Social History *(alcohol, drug, diet, exercise)*
- Cognitive Impairment
- Problem List
- Physical Exam (as indicated)
- Annual Preventive Counseling and Personalized Health Plan (Preventive Medicine)

STAFF

- Current Medications
- Social History *(tobacco*)
- Hearing Screening (vitals)
- Vision Screening (vitals)
- Immunizations
- Scan Form. Enter above in ROS
- Print Visit Summary

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