Annual Wellness Visit for Medicare Patients

Patient Health Questionnaire – PHQ-9

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all (0) | Several Days (1) | More than half of the days (2) | Nearly every day (3) |
| Little interest or pleasure in doing things |  |  |  |  |
| Feeling down, depressed, or hopeless |  |  |  |  |
| Trouble falling/staying asleep, sleeping too much |  |  |  |  |
| Feeling tired or having little energy |  |  |  |  |
| Poor appetite or overeating |  |  |  |  |
| Feeling bad about yourself, or that you are a failure, or have let yourself or your family down. |  |  |  |  |
| Trouble concentrating on things, such as reading the newspaper or watching TV. |  |  |  |  |
| 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 more than usual. |  |  |  |  |
| Thoughts that you would be better off dead or of hurting yourself in some way. |  |  |  |  |

1. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Please circle one.

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Total Score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Routine Tasks—**Please indicate if you do or do not need help performing the following:

1. Feeding yourself \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Getting from bed to chair \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Getting to the toilet \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Getting dressed \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Bathing or showering \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Walking across the room \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(includes using a cane or walker)

1. Using the telephone \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Taking your medications \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Preparing meals \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Managing money \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Doing the laundry \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Shopping for groceries \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Driving \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Climbing a flight of stairs \_\_\_\_no \_\_\_\_ yes if yes, who helps? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hearing—**Please check the appropriate answer

1. Do you find it hard to follow a conversation in a noisy room? \_\_\_\_ no \_\_\_\_ yes
2. Do you feel that people are mumbling? \_\_\_\_ no \_\_\_\_ yes
3. Do you ask people to speak up or repeat? \_\_\_\_ no \_\_\_\_ yes
4. Is it easier to understand men’s voices than women’s? \_\_\_\_ no \_\_\_\_ yes
5. Do you have trouble hearing over the telephone? \_\_\_\_ no \_\_\_\_ yes
6. Do you have problems hearing soft voices or whispers? \_\_\_\_ no \_\_\_\_ yes
7. Do you feel handicapped by a hearing problem? \_\_\_\_ no \_\_\_\_ yes
8. Have you had significant noise exposure from home or work? \_\_\_\_ no \_\_\_\_ yes
9. Do you experience ringing or noises in your ear(s)? \_\_\_\_ no \_\_\_\_ yes
10. Do you hear better with one ear than the other? \_\_\_\_ no \_\_\_\_ yes
11. Have any of your relatives (by birth) had a hearing loss? \_\_\_\_ no \_\_\_\_ yes

**Falling—**Please check the appropriate answer

1. Are you afraid of falling? \_\_\_\_ no \_\_\_\_ yes
2. Have you fallen in the past year? \_\_\_\_ no \_\_\_\_ yes
3. If you answered yes to #2, circle all that apply below

Tripped over something

Lightheadedness or heart palpitations

Loss of consciousness

Injured

Needed to see a doctor

Able to get up on your own

**Cognitive Screening—**Please check the appropriate answer

1. Do you feel you have a memory problem? \_\_\_\_ no \_\_\_\_ yes
2. Have you forgotten what you had for dinner yesterday? \_\_\_\_ no \_\_\_\_ yes
3. Do you have to keep lists so you don’t forget things? \_\_\_\_ no \_\_\_\_ yes
4. Do you frequently lose things at home or at work? \_\_\_\_ no \_\_\_\_ yes
5. Have you ever gotten lost while driving in your town? \_\_\_\_ no \_\_\_\_ yes
6. Have you forgotten why you are at a store? \_\_\_\_ no \_\_\_\_ yes
7. Have you had trouble balancing your checkbook lately? \_\_\_\_ no \_\_\_\_ yes
8. Do people often accuse you of repeating yourself? \_\_\_\_ no \_\_\_\_ yes

**Seatbelt Use—** Do you wear a seatbelt? \_\_\_\_ no \_\_\_\_ yes

**Exercise—** Do you exercise regularly? \_\_\_\_ no \_\_\_\_ yes

**Advance Directives—**Please check the appropriate answer

1. Do you have a living will? \_\_\_\_ no \_\_\_\_ yes
2. Do you have a healthcare power of attorney? \_\_\_\_ no \_\_\_\_ yes
3. Do you have a DNR order in place? \_\_\_\_ no \_\_\_\_ yes

**Health Maintenance / Immunization Form**

|  |  |  |
| --- | --- | --- |
| **Vaccine** | **ACIP recommendation** | **Date** |
| Pneumonia | Age 65 or 5 years after previous vaccination, once |  |
| Zostavax | Age 60, once |  |
| Influenza | Yearly |  |
| Tetanus/Diptheria | Every 10 years |  |

|  |  |  |
| --- | --- | --- |
| **Screening for Women** | **US Preventative Services Task Force Recommendation** | **Date** |
| Colonoscopy | Age 50-74, every 10 years |  |
| Bone Mineral Density | Age 65, every 2 years |  |
| Mammogram | Age 50-74, every 2 years |  |
| Cholesterol | Age 45+, if at risk for heart disease |  |
| Pap Smear | None after age 65 if not high risk |  |
| EKG | Not recommended, if asymptomatic and low risk |  |

|  |  |  |
| --- | --- | --- |
| **Screening for Men** | **US Preventative Services Task Force Recommendation** | **Date** |
| Colonoscopy | Age 50-74, every 10 years |  |
| Cholesterol | Age 35+ |  |
| AAA screening | Age 65-75, if smoking history, once |  |
| EKG | Not recommended, if asymptomatic and low risk |  |