Annual Wellness Visit Questionnaire Name: _____ Date: _____

1. How is your overall health?
   - O Excellent
   - O Good
   - O Fair
   - O Poor
2. What are your biggest concerns about managing your health?
   - O None
   - O I live in an unsafe environment
   - O Transportation to appointments
   - O Financial difficulty in paying for services/medicines
   - O Difficulty reading or understanding instructions
   - O I am lonely or don't have a lot of support at home
   - O I am often very tired
   - O I experience a lot of stress or anger
   - O I fall a lot at home
   - O Sexual health issues
3. How many times in the last 6 months have you been to the emergency room?
   - O 0 (zero)
   - O 1-2 times
   - O 3-4 times
   - O 5+ times
   - O I do not know
4. How many times in the last 6 months have you been admitted to the hospital?
   - O 0 (zero)
   - O 1-2 times
   - O 3-4 times
   - O 5+ times
   - O I do not know
5. What kind of diet do you follow?
   - O Keto/Low carb
   - O Low Cholesterol
   - O Balanced
   - O Gluten-Free
   - O Health High Fat
   - O Low Fat
   - O High Calorie
   - O Low Sodium
   - O Vegetarian
   - O Lactose Free
   - O Other: _____
   - O None
6. Have you lost 10 pounds over the past 6 months without trying to do so?
   - O Yes
   - O No
7. How often do you exercise?
   - O Never
   - O Daily
   - O Every other day
   - O 3-4 times a week
   - O Weekly
   - O Monthly

8. ADLs: Are you able to perform all ADLs (bathe, dress, eat, walk, transfer in/out of chair, use the bathroom, etc.) independently?
   - O Yes
   - O No
9. IDLs: Are you able to perform all IADLs (shop for groceries, use of telephone, housework, handle finances, drive/use public transportation, make meals, take medications, etc.) independently?
   - O Yes
   - O No
10. Does someone help you at home?
    - O Yes
      - (Who? _____)
    - O No
    - O Aide/Caregiver: _____
11. Many people experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experienced leaking of urine?
    - O Yes
    - O Yes, when I cough/sneeze
    - O Yes, when I sleep
    - O No
12. Do you have any concerns regarding home safety?
    - O No
    - O No smoke detectors
    - O Lack of railings or unstable railing
    - O Unsafe steps
    - O Poor lighting
    - O Uneven flooring
    - O Throw rugs
    - O Other: _____
13. Do you fasten your seatbelts in vehicles?
    - O Yes
    - O No
    - O I do not ride in vehicles
14. Do you or your family members have any concerns about your memory?
    - O Yes
    - O No
15. Have you had any problems with you vision?
    - O Yes
    - O No
16. Do you wear glasses or contacts?
    - O Yes
    - O No

17. Have you had any problems with your hearing?
    - **o** Yes
    - **o** No
18. Do you have partials or dentures?
    - **o** Yes
    - **o** No
19. Does your family or friends know what you want in an emergency situation or if you could not speak for yourself?
    - **o** Yes, I have a living will/Advance Directive
    - **o** Yes, I have a Healthcare Power of Attorney
    - **o** Yes, I have a durable power of attorney
    - **o** Yes, I have a POLST
    - **o** Yes, I have a completed 5 Wishes
    - **o** No
20. Have you fallen 2 or more times or have had a fall with injury in the past year?
    - **o** Yes
    - **o** No
21. Which of these assistive devices do you use?
    - **o** Cane
    - **o** Walker
    - **o** Wheelchair
    - **o** Crutches
    - **o** Other: _____
    - **o** None
22. Do you have trouble with your balance?
    - **o** Yes
    - **o** No
23. Are you afraid of falling?
    - **o** Yes
    - **o** No
24. Did you have a drink containing alcohol in the past year?
    - **o** Yes
    - **o** No

If you answered yes to the last question, please answer the next 3 questions. If you answered no, resume at question number 25.

1. How often did you have a drink containing alcohol in the past year?
    a. Never
    b. Monthly or less
    c. 2 to 4 times a month
    d. 2 to 3 times a week
    e. 4 or more times a week

2. How many drinks did you have in a typical day when you were drinking in the past year?
    a. 1 or 2 drinks
    b. 3 or 4 drinks
    c. 5 or 6 drinks
    d. 7 to 9 drinks
    e. 10 or more drinks
3. How often did you have 6 or more drinks on one occasion in the past year?
    a. Never
    b. Less than monthly
    c. Monthly
    d. Weekly
    e. Daily or almost daily

25. Have you misused prescription drugs or illicit drugs other than those for medical reasons in the past 12 months?
    - **O** Yes
    - **O** No
26. What is your current level of pain (0-10)?
    - **O** _____
27. Are you taking any prescription opioids for severe pain?
    - **O** Yes
    - **O** No
28. Do you currently use any tobacco products?
    - **O** Current smoker
        - Are you interested in quitting?
            - ☐ Yes
            - ☐ No
    - **O** Former smoker
        - When you start smoking? _____
        - When did you stop smoking? _____
    - **O** Nonsmoker (never)
    - **O** Light tobacco smoker
    - **O** Heavy tobacco smoker
    - **O** Other forms: _____