Annual Wellness Visit Questionnaire

Name: _____ Date of Birth: __ __ / __ __ / __ __ __ __

Today's date: __ __ / __ __ / __ __ __ __

Please complete this survey before seeing your doctor or nurse. Your responses will help us deliver the best care possible.

Section 1: Fall Risk Screening

1. Have you fallen in the last 6 months?
   ☐ No ☐ Yes
2. Do you have difficulty with walking or balance?
   ☐ No ☐ Yes
3. Do you use any assistive devices for walking (for example, a cane or walker)?
   ☐ No ☐ Yes

Section 2: Depression Screening – PHQ-9

1. In the past two weeks, how often have you felt little interest or pleasure in doing things?
   ☐ Not at all (0) ☐ Several Days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
2. In the past two weeks, how often have you felt down, depressed, or hopeless?
   ☐ Not at all (0) ☐ Several Days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
3. In the past two weeks, how often have you had trouble falling or staying asleep, or sleeping too much?
   ☐ Not at all (0) ☐ Several Days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
4. In the past two weeks, how often have you felt tired or had little energy?
   ☐ Not at all (0) ☐ Several Days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
5. In the past two weeks, how often have you had a poor appetite or overeating?
   ☐ Not at all (0) ☐ Several Days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
6. In the past two weeks, how often have you felt bad about yourself or your family?
   ☐ Not at all (0) ☐ Several Days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
7. In the past two weeks, how often have you had trouble concentrating on things, such as reading the newspaper or watching television?
   ☐ Not at all (0) ☐ Several Days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
8. In the past two weeks, how often have you experienced moving or speaking so slowly that other people could have noticed? Or in contrast, you have been so fidgety or restless that you have been moving around a lot more than usual?
   ☐ Not at all (0) ☐ Several Days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
9. In the past two weeks, how often have you had thoughts that you would be better off dead or thoughts of hurting yourself in some way?
   ☐ Not at all (0) ☐ Several Days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
10. If you checked off having any of the problems in Section 2, 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?
    ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Total Score: _____
Depression Scoring: 1-4 Minimal 5-9 Mild 10-14 Moderate 15-19 Moderately Severe 20-27 Severe

SONE HEALTH

Name: _____ Date of Birth: __ __ / __ __ / __ __ __ __

Today's date: __ __ / __ __ / __ __ __ __

Section 3: Functional Status Assessment

Assign 1 or 0 points per activity based on patient's level of functioning.

Activities Points (1 or 0)	**Independent (1 Point)** *No supervision, direction, or personal assistance*	**Dependent (0 Points)** *With supervision, direction, assistance, or total care*
Bathing Points:_____	**1 Point:** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area, or disabled extremity.	**0 Points:** Needs help with bathing more than one part of the body, getting in or out of the tub or shower, or requires total bathing.
Dressing Points:_____	**1 Point:** Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May need help tying shoes.	**0 Points:** Needs help dressing self or needs to be completely dressed.
Toileting Points:_____	**1 Point:** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**0 Points:** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
Transferring Points:_____	**1 Point:** Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	**0 Points:** Needs help moving from bed to chair or requires complete transfer.
Continence Points:_____	**1 Point:** Exercises complete self-control over urination and defecation.	**0 Points:** Is partially or totally incontinent of bowel or bladder.
Feeding Points:_____	**1 Point:** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**0 Points:** Needs partial or total help with feeding or requires parenteral feeding.
Total Points:_____ *Key: 6 = High (Patient Independent)* *0 = Low (Patient Very Dependent)*		

Put a check ✓ in the box that resembles the patient's highest functional level. Score points (1 or 0) associated with that box.

Ability to Use Telephone

✓	Activities:	Points
	Operates telephone on own initiative; looks up and numbers	1
	Dials a few well-known numbers	1
	Answers telephone but does not dial	1
	Does not use telephone at all	0

Shopping

✓	Activities:	Points
	Takes care of all shopping needs independently	1
	Shops for small purchases independently	0
	Needs to be accompanied on any shopping trip	0
	Completely unable to shop	0

Food Preparation

✓	Activities:	Points
	Plans, prepares, and serves adequate meals independently	1
	Prepares adequate meals if supplied with ingredients	0
	Heats and serves prepared meals, or prepares meals but does not maintain adequate diet	0
	Needs to have meals prepared and served	0

Housekeeping

✓	Activities:	Points
	Maintains house alone or with occasional assistance	1
	Performs light daily tasks like dishwashing, bed making	1
	Needs help with all home maintenance needs	1
	Does not participate in any housekeeping	0

Laundry

✓	Activities:	Points
	Does personal laundry completely	1
	Launders small items - rinses stockings etc.	1
	All laundry done by others	0

Mode of Transportation

✓	Activities:	Points
	Travels independently on public transportation or drives own car	1
	Arranges travel via taxi, no other public transportation	1
	Travels on public transportation when accompanied	1
	Travel limited with assistance of another	0
	Does not travel at all	0

Responsibility for Own Medications

✓	Activities:	Points
	Is responsible for taking medication in correct dosages at the correct time	1
	Takes responsibility if medication is prepared in advance	0
	Is not capable of dispensing own medication	0

Ability to Handle Finances

✓	Activities:	Points
	Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank)	1
	Manages day-to-day purchases but needs help with banking, making major purchases, etc	1
	Incapable of handling money	0

Total Points _____

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Today's date: __ __ / __ __ / __ __ __ __

Section 4: Home Safety Questionnaire

1. When you walk through a room, do you have to walk around furniture?
   ☐ Yes ☐ No
2. Do you have throw rugs on the floor?
   ☐ Yes ☐ No
3. Do you have to walk over or around cords or wires (like cords from lamps, extension cords, or telephone cords)?
   ☐ Yes ☐ No
4. Are papers, shoes, books, or other objects on the stairs, or are some steps broken or uneven?
   ☐ Yes ☐ No
5. Are you missing a light over the stairway or is it burned out?
   ☐ Yes ☐ No
6. If you have handrails, are the handrails loose or broken?
   ☐ Yes ☐ No
7. If the steps are carpeted, is the carper loose or torn?
   ☐ Yes ☐ No
8. In your kitchen, are the things you use often on high shelves?
   ☐ Yes ☐ No
9. If you have a step stool, is your stool unsteady?
   ☐ Yes ☐ No
10. In the bedroom, is the light near the bed hard to reach?
    ☐ Yes ☐ No
11. Is the path from your bed to the bathroom dark?
    ☐ Yes ☐ No
12. In the bathroom, is the tub or floor slippery?
    ☐ Yes ☐ No
13. Do you need some support when you get in and out of the tub or up from the toilet (grab bars, etc.)?
    ☐ Yes ☐ No
14. Do you have working smoke detectors in your home or apartment?
    ☐ Yes ☐ No
15. Do you regularly change the batteries in your smoke detectors?
    ☐ Yes ☐ No
16. If you have a space heater, is it far away from flammable object?
    ☐ Yes ☐ No
17. Is there a phone in your bedroom?
    ☐ Yes ☐ No
18. Do you have a fire exit plan?
    ☐ Yes ☐ No

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Section 5: Health Risk Assessment

1. During the last 4 weeks, has your physical/emotional health limited your social activities?
   ☐ Yes ☐ No
2. During the last 4 weeks, was someone available to help you if you needed/wanted help?
   ☐ Yes ☐ No
3. During the last 4 weeks, how would you rate your health in general?
   ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor
4. Do you always fasten your seatbelt when you're in the car?
   ☐ Yes ☐ No
5. How often during the last 4 weeks have you been bothered by any of the following problems?
   a. Sexual problems
      ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently
   b. Trouble eating well
      ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently
   c. Teeth or denture problems
      ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently
   d. Tiredness or fatigue
      ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently
6. Do you exercise for about 20 minutes three or more days per week?
   ☐ Yes ☐ No
7. Have you been given any information to help you keep track of your medications?
   ☐ Yes ☐ No
8. Are you confident that you can control/manage most of your health problems?
   ☐ Yes ☐ No

Section 6: Pain Assessment

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

*If any pain, please describe:*_____

Section 7: Tobacco Use

1. Are you a current smoker? *(This includes smoking cigarettes or cigars, using e-cigarettes, or vaping)*
   ☐ No – never smoker ☐ No – former smoker ☐ Yes, current smoker
   Year I quit: *Specify type and frequency:*
2. Do you use smokeless tobacco, such as dip or chewing tobacco?
   ☐ No ☐ Yes, current user - *Specify type and frequency:*
3. If you are a current smoker or user of smokeless tobacco, would you be interested in quitting?
   ☐ Yes ☐ No ☐ Not a current smoker

Are there any other concerns or questions you'd like to discuss at your appointment?

_____

_____

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