Medicare Annual Wellness Visit Patient Questionnaire

Patient's name:_____ DOB_____ Exam Date_____

Who is your provider: ❒ Dr. Cornett ❒ Dr. Hoermann ❒ Dr. Ramsay ❒ Dr. Rickerhauser ❒ Dr. Stafford
❒ Erika Benfield, NP ❒ Kelle Pardi, NP

List Your Drug Allergies_____

Past personal illnesses, injuries, operations or diagnoses	Date	Hospitalized?

Tobacco use: ❒ Yes ❒ No If yes, (smoke or chew) how many packs per day?_____
Alcohol use: ❒ Yes ❒ No If yes, how many drinks per day?_____
Drug Use: ❒ Yes ❒ No If yes, describe_____

List the name of Medications, Supplements or Vitamins that you take	**Route (Oral, topical, etc.)**	**Dose**	**Frequency (example: 1-2 times a day)**

****Add additional page if further space for Medications is needed****

Current List of Patient's Other Providers and Suppliers

NAME	SPECIALTY	REASON

Please complete reverse side ⇨

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Family History of Parents, Grandparents, Siblings (check those that apply)

❒ Alcoholism	❒ Diabetes	❒ Hypertension	❒ Obesity
❒ Arthritis	❒ Heart Disease	❒ Kidney Disease	❒ Stroke
❒ Cancer	❒ High Cholesterol	❒ Liver Disease	❒ Thyroid Disease
Additional History/Notes:			

Number of servings of fruits and vegetables do you have per day? _____

How many times a week do you exercise?_____Duration?_____Type? _____

Hearing Loss Screen

1. Do you have trouble hearing the TV or radio when others don't? ❒ Yes ❒ No
2. Do you have to strain or struggle to hear/understand conversations? ❒ Yes ❒ No

Function Screen

1. Do you need help with preparing meals, transportation, shopping, taking your medications, managing finances, or other activities of daily living? ❒ Yes ❒ No
2. Do you live alone? ❒ Yes ❒ No

Fall Screen

1. Have you had an injury from a fall in the last year? ❒ Yes ❒ No
2. Have you had more then one fall in the last year? ❒ Yes ❒ No

Home Safety Screen

1. Does your home have rugs, poor lighting, or a slippery bathtub/shower? ❒ Yes ❒ No
2. Does your home LACK grab bars in bathrooms, handrails on stairs or steps? ❒ Yes ❒ No
3. Does your home LACK functioning smoke alarms? ❒ Yes ❒ No

Advanced Care Planning

Patient Consent: "I consent to discuss end-of-life issues with my healthcare provider."

_____ _____

Patient/Guardian Signature Date

CORNERSTONE CLINIC

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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**
☐	☐	☐	☐