SIERRA VISTA HOSPITAL & CLINICS
800 East 9th Avenue, Truth or Consequences, NM 87901
Hospital: 575-894-2111 | Clinic: 575-894-3221

MEDICARE ANNUAL WELLNESS VISIT

Patient Name: _____ **DOB:**_____
Date:_____

Care Providers/Specialists

Provider Name	Specialty	Reason for seeing provider

Medical Devices (Mark if applicable)

	None		Pacemaker
	Implantable cardioverter-defibrillator		Other
	Insulin pump		
	Medication pump		

Durable Medical Equipment (Mark if applicable)

	Oxygen		Commode		Immobilizer
	Walker		CPAP		Other
	Wheelchair		Spirometry		
	Bed		Splint		

Oral Health (Circle if applicable)

Dental exam in the last 12 months? Yes No
Dental concerns: None Tooth Pain Gum pain chipped or missing teeth other

Since last visit

Have you been hospitalized since your last visit? No Yes

If yes, when, where and for what conditions: _____
_____
_____

Do you have an Advanced Directive, Living Will, Medical Durable Power of Attorney? Yes No

Please bring it with you to your appointment so that a copy can be placed in your chart.

Substance Use (Circle answer)

How often do you have a drink containing alcohol?

Never Monthly or less 2-4 times/mo. 2-3 times/week 4 or more times/week

Do you have any personal history of substance abuse?

Alcohol Illegal drugs Prescription drugs

Health Risk Assessment Questionnaire

Patient's Name: _____ DOB: _____

In the past 2 weeks, have you experienced any of the following?

1. Little interest or pleasure in doing things ☐ Yes ☐ No
2. Feeling Down, Depressed or Hopeless ☐ Yes ☐ No

3. Are there hazards in your house that might hurt you? ☐ Yes ☐ No
4. Have you fallen in the past year? ☐ Yes ☐ No
5. Are you worried you might fall? ☐ Yes ☐ No
6. Do you use a cane or walker? ☐ Yes ☐ No
7. Do you need someone to help you get up in the morning? ☐ Yes ☐ No
8. In the past 4 weeks, have you fallen or felt dizzy when standing up? ☐ Yes ☐ No

9. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house? ☐ Yes ☐ No
10. Do you have trouble consistently taking or remembering to take all of your medications as prescribed? ☐ Yes ☐ No

11. During the past four weeks, have you had pain present? ☐ Yes ☐ No
    Primary pain location:

Numeric rating scale:

Mild Moderate Severe Unbearable

1 2 3 4 5 6 7 8 9 10

12. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?) ☐ Yes ☐ No
13. Can you go shopping for groceries or clothes without someone's help? ☐ Yes ☐ No
14. Can you prepare your own meals? ☐ Yes ☐ No
15. Can you do your housework without help? ☐ Yes ☐ No
16. Can you handle your own money without help? ☐ Yes ☐ No
17. Can you keep track of your own medications without help? ☐ Yes ☐ No

18. How have things been going for you during the past four weeks?

_____

_____

19. During the past four weeks, how would you rate your health in general?
    ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
20. During the past four weeks, was someone available to help you if you needed and wanted help?
    ☐ Yes, as much as I wanted ☐ Yes, quite a bit
    ☐ Yes, some ☐ Yes, a little ☐ No, not at all.
21. During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
    ☐ Not at all ☐ Slightly ☐ Moderately
    ☐ Quite a bit ☐ Extremely
22. During the past four weeks, how often have you been bothered by any of the following problems? (Circle answers that apply)
    ☐ Sexual problems: Often Sometimes Never
    ☐ Trouble eating well: Often Sometimes Never
    ☐ Teeth or denture problems: Often Sometimes Never
    ☐ Problems using the phone: Often Sometimes Never
23. How confident are you that you can control and manage most of your health problems?
    ☐ I do not have any health problems ☐ Very confident
    ☐Somewhat confident ☐ Not very confident.
24. Are you having difficulties driving your car?
    ☐ Yes ☐ No ☐ N/A ☐ Sometimes ☐ Often
25. Do you always fasten your seat belt when you are in a car?
    ☐ Always ☐ Occasionally ☐ Never

_____ _____

Patient Signature Date