MEDICARE ANNUAL WELLNESS VISIT

Sierra Vista Hospital & Clinics
800 East 9th Avenue, Truth or Consequences NM 87901
Hospital: 575.894.2111 Clinic: 575.894.3221

Patient Name _____ **Date of Birth** _____ / _____ / _____

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 Wheelchair		CPAP Spirometry		Other
	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? ☐ Yes ☐ No

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

_____

Revision Date: 05.01.25

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

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: _____ Date of Birth: _____ / _____ / _____

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 (i.e., 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? (Check ALL 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 no 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