



Annual Wellness Visit Questionnaire

Medicare Annual Wellness Visit (AWV) • Blue Sky MD Health

Office Location: ☐ Hendersonville ☐ Sylva

Patient Name _____ Date of Birth _____

Depression Screening (PHQ-2)

Over the past two weeks, how often have you been bothered by:	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

Wellness Profile

Number of falls in the last 12 months: _____ Emergency room visits in the last 6 months: _____

Hospital stays in the last 6 months: _____

Do you have any of the following existing conditions?

☐ Anxiety ☐ Alzheimer's ☐ Dementia ☐ Depression ☐ None

New vision problems: ☐ Yes ☐ No

Decreased hearing: ☐ Yes ☐ No

Do you or your family have concerns about your memory? ☐ Yes ☐ No

Overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please check all activities of daily living that require assistance of any kind (human or mechanical):

- | | | |
|---|--|-------------------------------------|
| ☐ Ambulation / transferring from sitting to standing | ☐ Bathing / showering | ☐ Continence |
| ☐ Dressing | ☐ Feeding | ☐ Finances |
| ☐ Food preparation | ☐ Housekeeping | ☐ Laundry |
| ☐ Medication management | ☐ Shopping | ☐ Toileting |
| ☐ Transportation | | |

Other contributing difficulties

- | | | |
|---|---|---|
| ☐ None | ☐ Live in an unsafe environment | ☐ Lacking transportation |
| ☐ Financial difficulty | ☐ Difficulty reading or understanding instructions | ☐ Lonely |
| ☐ Frequent falls | | |

Vaccines

☐ Flu shot (one every 12 months)

Date: _____

☐ Pneumonia shot (Medicare Part B covers the first shot at any time and a different second shot if given at least one year after the first)

Date: _____

☐ Hepatitis B shot

Date: _____

Hepatitis B risk factors (check any that apply):

☐ Hemophilia

☐ Have ESRD

☐ Diabetic

☐ Live with someone who has Hepatitis B

Screenings

Males only (over age 50):

☐ Prostate screening (digital rectal exam)

Date: _____

☐ Prostate screening (bloodwork)

Date: _____

Females only:

☐ Pap smear

Date: _____

☐ Mammogram

Date: _____

Immunizations

☐ TDAP

Date: _____

☐ Pneumovax 23

Date: _____

☐ Shingrix

Date: _____

☐ Prevnar 13

Date: _____

Preventive Screenings

Last colonoscopy (date): _____

Results: ☐ Normal ☐ Abnormal

Bone scan / DEXA (date): _____

Results: ☐ Normal ☐ Abnormal

Surgical & Hospitalization History

Please list surgeries / hospitalizations and the month and year of each.

Surgery / Hospitalization	Month / Year

Family History

Do any of the following apply to your immediate blood relatives? Check all that apply.

Condition	Mom	Dad	Sister	Brother
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart attack / stroke	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Mental health condition	☐	☐	☐	☐

Social History

Tobacco use (cigarettes, cigars, or chew): ☐ Daily ☐ Socially ☐ Quit ☐ Never

Alcohol use: ☐ Daily ☐ Socially ☐ Quit ☐ Never

Illicit drug use: ☐ Daily ☐ Socially ☐ Quit ☐ Never

If yes, please specify type used: ☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Prescription ☐ Other:

Personal Medical History

Please check if **you** have been diagnosed with any of the following:

- | | | | |
|---------------------------------------|--|--|---|
| ☐ Afib | ☐ Anxiety | ☐ Arthritis | ☐ Asthma |
| ☐ Cancer | ☐ COPD | ☐ Coronary artery disease | ☐ Depression |
| ☐ Diabetes | ☐ Fibromyalgia | ☐ GERD / acid reflux | ☐ Heart attack(s) |
| ☐ Hepatitis | ☐ Hernia | ☐ High blood pressure | ☐ High cholesterol |
| ☐ Osteoporosis | ☐ Thyroid dysfunction | ☐ Tuberculosis | ☐ Ulcers |

Current Providers & Suppliers of Healthcare

	Provider / Group / Clinic Name	City & State
Primary care provider		
Cardiologist		
Pain specialist		
Pharmacy		
Pulmonary specialist		
Dentist		
Other		

Review of Symptoms

Please check any of the following that apply to you currently or in the **last 2 weeks**:

- | | |
|--|---|
| ☐ Constitutional: Fever, chills, sleep issues, sweating, fatigue, weight gain or weight loss | ☐ Respiratory: Shortness of breath at rest, wheezing, cough |
| ☐ Musculoskeletal: New or worsening joint pain, extremity weakness, muscle aches | ☐ HEENMT: Vision loss, blurry or double vision, eye pain, hearing loss, ear pain, ringing in ears, nosebleed, sore throat, swallowing issues, voice changes |
| ☐ Cardiovascular: Chest pain, palpitations, leg swelling | ☐ Skin: Blisters, itching, rash, ulcers, changing moles |
| ☐ Gastrointestinal: Abdominal pain, change in bowel habits, diarrhea, constipation, blood in stool, nausea | ☐ Neurological: Balance difficulty, dizziness, difficulty speaking, headaches, tremor, memory loss |
| ☐ Endocrine: Cold intolerance, heat intolerance, frequent urination, excessive thirst | ☐ Hematology: Easy bruising, swollen glands |
| ☐ Genitourinary: Difficulty urinating, painful urination, flank pain, incontinence, erectile dysfunction | ☐ Psychiatric: Auditory or visual hallucinations, substance abuse, thoughts of suicide, anxiety, depression |