Fredericksburg Christian Health Center
Medicare Annual Wellness Assessment

Patient Name	Birth Date	Today's Date

Please answer the questions below as accurately and honestly as you can.This will help us better understand you and your healthcare needs.

Falling

1) Do you have any problems with balance or falling? Yes No
2) Have you fallen in the past year? Yes No
3) Do you have difficulty getting up from a chair or out of bed? Yes No
4) Do you have trouble with your vision that is not corrected with contacts or glasses? Yes No

Physical Activities

1) Do you walk or exercise regularly? Yes No
2) Can you walk more than a block without having to stop? Yes No
3) Can you bathe or use the toilet without assistance? Yes No
4) Do you have trouble controlling your bladder or bowels? Yes No
5) Are you able to dress yourself? Yes No
6) Do you wear hearing aids? Yes No
7) Are you able to hear well? Normal Fair Poor

Nutrition

1) Can you eat without assistance? Yes No
2) Do you need assistance with preparing meals? Yes No
3) Are you trying to lose weight? Yes No
4) Have you lost weight without trying to do so? Yes No
5) How is your appetite? Normal Poor

Mood

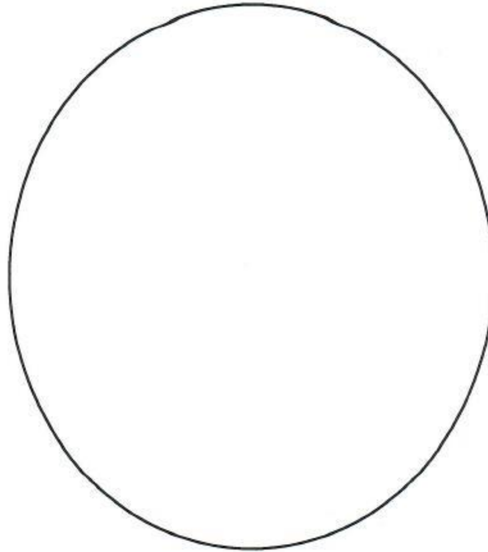
In the last 2 weeks have you been bothered by the following problems?

1) Little interest or pleasure in doing things? Not at all Some Days Most Days Nearly Everyday
2) Feeling down, depressed, or hopeless? Not at all Some Days Most Days Nearly Everyday

Patient: Date:

Cognition

1) How is your memory? Good Fair Poor
2) Do you handle your finances or balance your checkbook yourself? Yes No
3) Do you drive? Yes No
4) Please complete the picture of a clock below, by writing in the numbers for the clock and the hands so they point to a time of 1:30.



Substance Use

1) Do you smoke, vape, or use chewing tobacco? Yes No
   If so, have you thought about quitting? Yes No
2) Were you ever a smoker? Yes No
   If so, were you a heavy smoker or smoked for over 20 years? Yes No

   For Nurse Use: Pk/yr=
3) Do you drink alcohol? Yes No
   If you drink alcohol, do you drink on most days of the week or ever drink more than two drinks in one sitting? Yes No

   If you answered yes, please answer the following questions
   Do you get annoyed when asked about your drinking? Yes No
   Has anyone ever suggested you cut down on your drinking, Or have you ever tried to cut down? Yes No
   Do you ever feel guilty about your drinking? Yes No
   Do you ever feel you need an “eye opener” in the morning? Yes No
4) Do you ever use someone else's prescription medications such as pain medications or anxiety pills, or use illegal substances? Yes No

End of Life Care: Do you have a living will or advanced directive? Yes No