ATLANTA CENTER FOR MEDICINE
MEDICARE ANNUAL WELLNESS
QUESTIONNAIRE

Please complete this checklist before seeing your
doctor or nurse. Your answers will help us to
deliver the best healthcare possible.

1. What is your age?
   □ 65-69  □ 70-79  □ 80 or older

2. Are you a male or a female?
   □ Male   □ Female

3. During the past four weeks how much have
   you been bothered by emotional problems such
   as feeling anxious, depressed, irritable, sad, or
downhearted and blue?
   □ Not at all.
   □ Slightly.
   □ Moderately.
   □ Quite a bit.
   □ Extremely.

4. 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.

5. During the past four weeks, how much bodily
   pain have you generally had?
   □ No pain.
   □ Very mild pain.
   □ Mild pain.
   □ Moderate pain.
   □ Severe pain.

6. During the past four weeks, was someone
   available to help you if you needed and wanted
   help?
   For example, if you felt very nervous, lonely, or
   blue; got sick and had to stay in bed; needed
   someone to talk to; needed help with daily
   chores; or needed help just taking care of
   yourself.)
   □ Yes, as much as I wanted.
   □ Yes, quite a bit.
   □ Yes, some.
   □ Yes, a little.
   □ No, not at all.

7. During the past four weeks, what was the
   hardest physical activity you could do for at least
two minutes?
   □ Very heavy.
   □ Heavy.
   □ Moderate.
   □ Light.
   □ Very light.

8. Can you get to places out of walking distance
   without help? (For example, can you travel
   alone on buses or in taxis, or drive your own
   car?)
   □ Yes   □ No

9. Can you go shopping for groceries or clothes
   without someone’s help?
   □ Yes   □ No

10. Can you prepare your own meals?
    □ Yes   □ No

11. Can you do housework without help?
    □ Yes   □ No

12. 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

13. Can you handle your own money without
    help?
    □ Yes   □ No

14. During the past four weeks, how would you
    rate your health in general?
    □ Excellent.
    □ Very good.
    □ Good.
    □ Fair.
    □ Poor.

15. How have things been going for you during
    the past four weeks?
    □ Very well; could hardly be better.
    □ Pretty well.
    □ Good and bad parts about equal.
    □ Pretty bad.
    □ Very bad; could hardly be worse.
16. Are you having difficulties driving your car?
   □ Yes, often.
   □ Sometimes.
   □ No.
   □ Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?
   □ Yes, usually.
   □ Yes, sometimes.
   □ No.

18. How often during the past four weeks have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falling or dizzy when standing up.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Sexual problems.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Trouble eating well.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Teeth or denture problems.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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</tr>
<tr>
<td>Tiredness or fatigue.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

19. Have you fallen two or more times in the past year?
   □ Yes   □ No

20. Are you afraid of falling?
    □ Yes   □ No

21. Are you a smoker?
    □ No.
    □ Yes, but I might quit.
    □ Yes, and I’m not ready to quit.

22. During the past four weeks, how many drinks of wine, beer or other alcoholic beverages did you have?
    □ 10 or more drinks per week.
    □ 6-9 drinks per week.
    □ 2-5 drinks per week.
    □ One drink or less per week.
    □ No alcohol at all.

23. Do you exercise for about 20 minutes, three or more times per week?
    □ Yes, most of the time.
    □ Yes, some of the time.
    □ No, I usually don’t exercise this much.

24. Have you been given any information to help you with the following:
    Hazards in your house that might hurt you?
    □ Yes   □ No
    Keeping track of your medications?
    □ Yes   □ No

25. How often do you have trouble taking medicines the way you’ve been told to take them?
    □ I do not have to take medicine.
    □ I always take them as prescribed.
    □ Sometimes I take them as prescribed.
    □ I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?
    □ Very confident.
    □ Somewhat confident.
    □ Not very confident.
    □ I do not have any health problems.

27. What is your race? (Check all that apply.)
    □ White.
    □ Black or African American.
    □ Asian.
    □ Native Hawaiian
    □ Other Pacific Islander.
    □ American Indian or Alaskan Native.
    □ Hispanic or Latino origin or descent.
    □ Other.

Thank you very much for completing your Medicare Annual Wellness Questionnaire. Please bring your completed questionnaire with you to your Annual Wellness Visit, and give it to your doctor or nurse.