MEDICARE ANNUAL WELLNESS VISIT (AWV) ENCOUNTER FORM

FIRST NAME:	LAST NAME:	DATE OF BIRTH:

Please list all other Providers you see outside of Park Medical Centers within the last 2 years including, medical suppliers, pharmacies, and the reason you see them.

DATE	NAME	PURPOSE/REASON

DEPRESSION SCREENING PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**NOT AT ALL (0)**	**SEVERAL DAYS (1)**	**MORE THAN HALF THE DAYS (2)**	**NEARLY EVERY DAY (3)**
1. Little interest or pleasure in doing things	◯	◯	◯	◯
2. Feeling down, depressed, or hopeless	◯	◯	◯	◯
3. Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
4. Feeling tired or having little energy	◯	◯	◯	◯
5. Poor appetite or overeating	◯	◯	◯	◯
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	◯	◯	◯	◯
7. Trouble concentrating on things, such as reading the newspaper or watching television	◯	◯	◯	◯
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	◯	◯	◯	◯
9. Thoughts that you would be better off dead, or of hurting yourself	◯	◯	◯	◯
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	◯ NA ◯ Not difficult at all ◯ Somewhat difficult		◯ Very difficult ◯ Extremely difficult	

PAIN ASSESSMENT

If any pain within the past 7 days, describe the type of pain and location: Check all that apply: ◯ Head ◯ Chest ◯ Abdomen ◯ Pelvis ◯ Neck	Check all that apply: ◯ Mid-back ◯ Lower Back ◯ Right Upper Extremity ◯ Left Upper Extremity ◯ Right Lower Extremity ◯ Left Lower Extremity	Select the number that best describes the pain level ◯ 0 – nothing hurts ◯ 2 – hurts a little ◯ 4 – hurts a little more ◯ 6 – hurts even more ◯ 8 – hurts a whole lot ◯ 10 – hurts worst

ACTIVITIES OF DAILY LIVING (ADL)			
Activity		YES	NO
CONTINENCE	YES = incontinent (or catheterized and unable to manage alone) NO = independent	○	○
MOBILITY/TRANSFERRING	YES = unable, needs help in moving from bed to chair or requires complete transfer, uses wheelchair NO = moves in and out of bed unassisted (mechanical aids are acceptable)	○	○
EATING	YES = needs partial or total help with eating or requires parenteral feeding NO = gets food from plate into mouth independently (prep of food may be done by another person)	○	○
BATHING	YES = needs help with bathing or getting in and out of the shower NO = independent (bathes self completely, disabled extremity)	○	○
DRESSING	YES = needs help with dressing self or needs to be completely dressed NO = gets clothes from closet and puts on clothes complete with fasteners	○	○
TOILET USE	YES = needs help transferring to the toilet, unable to clean self, uses bed pan or commode NO = goes to toilet, gets on and off, cleans genital area without help	○	○
WALKING	YES = Needs help from another person with walking or completely unable to walk NO = Independent (able to walk by themselves or cane or other assistive devices)	○	○
HOUSEWORK, HOME REPAIR, LAUNDRY, MEAL PREPARATION	YES = Unable to perform tasks NO = Independent (able to perform tasks independently or with just minimal assistance)	○	○
TRANSPORTATION	YES = Unable to drive or use public transportation NO = Independent (able to drive or use public transportation)	○	○
MEDICATIONS	YES = Unable to handle their own medications NO = Independent (able to handle medications independently or with just minimal assistance)	○	○
FINANCES	YES = Unable to handle their own finances NO = Independent (can handle their own finances independently or with just minimal assistance)	○	○

HOME HEALTH SCREEN	YES	NO	N/A
Have you fallen AT ANY TIME within the last 12 months?	○	○	
If you fell, did you fall more than once?	○	○	○
If you fell, did you get injured?	○	○	○
Home has throw rugs, poor lighting or slippery bathtub/shower?	○	○	
Home lacks grab bars in bathroom or lacks handrails on stairs?	○	○	
Home has no functioning smoke alarms?	○	○	

URINARY INCONTINENCE ASSESSMENT (Age 65+)	YES	NO	N/A
In the past 6 months, have you accidentally leaked urine?	○	○	
If yes, was the urine leakage a problem for you?	○	○	○
Did leaking of urine make you change your daily activities?	○	○	○
Did leaking of urine interfere with your sleep?	○	○	○

ADVANCED CARE PLANNING

Check all that apply

Do you have:
- ○ Advance Directives
- ○ Living Will
- ○ Surrogate Decision Maker
- ○ Actionable Medical Orders
- ○ None Of The Above

Patient/caregiver desires Advanced Care Planning??
- ○ Yes
- ○ No

You have given a copy to your Provider?
- ○ Yes
- ○ No

RISK ASSESSMENT

1. In general, would you say your health is?
- ◯ Good
- ◯ Fair
- ◯ Poor

2. In the past 7 days, how often did you exercise for at least 20 minutes in a day?
- ◯ More than 4 days
- ◯ 2 - 4 days
- ◯ Not At All

Exercise includes walking, housekeeping, jogging, weights, a sport or playing with your kids. It can be done on the job, around the house, just for fun or as a work-out.

3. How intense was your exercise?
- ◯ Heavy (like fast running, jogging, stair climbing, swimming)
- ◯ Moderate to light (like walking, stretching)
- ◯ Not currently exercising

4. In the past 7 days, how often did you eat 1 or more servings of fruits or vegetables in a day?
- ◯ More than 4 days
- ◯ 2 - 4 days
- ◯ Not At All

5. In the past 7 days, how often did you eat 1 or more servings of high fiber or whole grain foods in a day?
- ◯ More than 4 days
- ◯ 2 - 4 days
- ◯ Not At All

6. In the past 7 days, how often did you eat 1 or more servings of fried or high fat foods in a day?
- ◯ More than 4 days
- ◯ 2 - 4 days
- ◯ Not At All

7. In the past 7 days, how often did you eat 1 or more servings of sugar-sweetened (not diet) beverages in a day?
- ◯ More than 4 days
- ◯ 2 - 4 days
- ◯ Not At All

8. In the past 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time?
- ◯ Not At All
- ◯ 2 - 4 days
- ◯ More than 4 days

9. Do you ever drive after drinking or ride with a driver who has been drinking?
- ◯ Yes
- ◯ No
- ◯ Not Sure

10. In the past 2 weeks, how often have you felt tense, anxious or on edge?
- ◯ Almost never
- ◯ Some of the time
- ◯ Most of the time

11. In the past 2 weeks, how often were you <u>not</u> able to stop worrying or control your worrying?
- ◯ Almost never
- ◯ Some of the time
- ◯ Most of the time

12. How often is stress a problem for you in handling such things as your health, finances, family or social relationships, work?
- ◯ Never or rarely
- ◯ Some of the time
- ◯ Most of the time

13. How often do you get the social and emotional support you need?
- ◯ Almost Always
- ◯ Rarely
- ◯ Never

14. How would you describe the condition of your mouth and teeth (including false teeth or dentures)?
- ◯ Good
- ◯ Fair
- ◯ Poor

15. Each night, how many hours of sleep do you get?
- ◯ At least 8
- ◯ 4-7
- ◯ Less than 4

16. Do you snore, or has anyone told you that you snore?
- ◯ Yes
- ◯ No
- ◯ Not sure

17. How often have you felt sleepy, in the past 7 days?
- ◯ Often
- ◯ Sometimes
- ◯ Never

18. Do you always fasten your seat belt when you're in a car?
- ◯ Always
- ◯ Usually
- ◯ Never

19. Are you aware of your results for tests performed in the past year; such as Blood Pressure, Cholesterol, Blood Glucose, Hemoglobin A1c?
- ◯ Yes
- ◯ No
- ◯ Not sure