Medicare Wellness Visit – Review

Overall, compared to 1 year ago, are you
BETTER **WORSE** or **THE SAME** (circle one)

Do you smoke? **Y** **N** how much_____per day

Do you drink alcohol? **Y** **N** how much_____per day

Have you had a **FALL** in the last 12 months? **Y** **N**
If yes, how many times? _____
If yes, were you injured? _____

What do you use for stability? (circle one)
CANE **WALKER** **WHEELCHAIR** **NOTHING**

Do you have trouble **HEARING**? **Y** **N**
Would you like a referral for **HEARING TESTING**? **Y** **N**

Do you need help or assistance with any of the following?

Bathing	**Y**	**N**
Toileting	**Y**	**N**
Dressing	**Y**	**N**
Keeping up with Medications	**Y**	**N**
Shopping	**Y**	**N**
Finances/Money Management	**Y**	**N**

Do you have a Smoke Alarm?	**Y**	**N**
Do you have a Carbon Monoxide Alarm?	**Y**	**N**
Do you have elevated Radon level in your home?	**Y**	**N**
If so, has it been treated?	**Y**	**N**
Do you have a Gun at home?	**Y**	**N**
Do you wear your seatbelt?	**Y**	**N**

Do you have a formal Advanced Directive?	**Y**	**N**
Do you have a formal Medical Power of Attorney?	**Y**	**N**