Banner Health®

Dear Patient:

Thank you for choosing Banner for your Annual Wellness Visit.

We want to provide you with care that promotes health and wellness. Your Medicare Annual Wellness Visit is a great way to provide that care. During the visit we will assess current health risks and discuss ways to reduce future risks to your health. Medicare provides this assessment, at no cost to you, once a year to help identify health risks, promote wellness, and keep you healthy.

This is not the same as a traditional yearly physical. No physical exam will be completed during this visit. If you need extra time to talk about your symptoms or current conditions, please call to schedule a separate visit with your Primary Care Provider.

Visit Will Include	Visit Will **Not** Include
✅ Assessment of your health status	❌ A Physical Exam
✅ Discussion of ways to promote health	❌ Address current symptoms or health issues
✅ Screenings for potential health risks	
✅ Immunizations	
✅ Ordering of lab tests	

What to bring with you:

- ☐ Complete attached form
- ☐ Copy of your Advance Directive or Medical Power of Attorney
- ☐ List of current medications and supplements
- ☐ List of all of your current medical providers and doctors
- ☐ Medical records for visits outside of Banner

Thank you for choosing Banner Health!

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ANNUAL MEDICARE WELLNESS QUESTIONNAIRE

Patient Name:_____ Date of Birth:_____/_____/_____

Please complete this questionnaire before seeing your provider. The answers to your questions will help us provide you with the care you deserve to support your well-being and quality of life.

In the past two weeks, how often have you been bothered by any of the following problems.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	❑	❑	❑	❑
2. Feeling down, depressed, or hopeless	❑	❑	❑	❑

1. Are there hazards in your house that might hurt you?	Yes	No
2. Have you fallen in the past year? If Yes, number of falls _____ Did your fall result in injury?	Yes	No
3. Are you worried you might fall?	Yes	No
4. Do you use a cane or walker?	Yes	No
5. Do you need someone to help you get up in the morning?	Yes	No
6. In the past four weeks, have you fallen or felt dizzy when standing up?	Yes	No
7. 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
8. Do you have trouble consistently taking or remembering to take all of your medications as prescribed?	Yes	No
9. During the past four weeks, have you had pain present? If Yes, location of your pain: _____ Using the scale below, how would you rate your pain: _____	Yes	No
10. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)	Yes	No
11. Can you go shopping for groceries or clothes without someone's help?	Yes	No
12. Can you prepare your own meals?	Yes	No
13. Can you do housework without help?	Yes	No
14. Can you handle your own money without help?	Yes	No
15. Can you keep track of your own medications without help?	Yes	No

Rating	Pain Level
0	No pain
1-3	Mild pain
4-6	Moderate Pain
7-10	Severe Pain

16. How have things been going for you during the past four weeks?
❑ Very well ❑ Pretty well ❑ Good and bad parts about equal ❑ Pretty bad ❑ Very bad

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

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(03/2018)

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18. During the past four weeks, was someone available to help you if you needed and wanted help?
❑ Yes, as much as I wanted ❑ Yes, quite a bit ❑ Yes, some ❑ Yes, a little ❑ No, not at all

19. 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

20. During the past four weeks, how often have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Sexual problems	❑	❑	❑	❑	❑
Trouble eating well	❑	❑	❑	❑	❑
Teeth or denture problems	❑	❑	❑	❑	❑
Problems using the phone	❑	❑	❑	❑	❑

21. How confident are you that you can control and manage most of your health problems?
❑ No health problems ❑ Very confident ❑ Somewhat confident ❑ Not very confident

21. Are you having difficulties driving your car?
❑ Not Applicable ❑ No ❑ Sometimes ❑ Yes, often

23. Do you always fasten your seat belt when you are in a car?
❑ Always ❑ Occasionally ❑ Never

24. List all providers you are currently seeing and reason for visit:

Name	Reason

25. List all ancillary services you are currently using and the reason (example: oxygen, medical equipment, etc)

Name	Reason

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