USMD Health System

MEDICARE ANNUAL VISIT QUESTIONNAIRE

Date: _____

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

Please list the names and specialties of other providers you are seen by on a regular basis:

NAME	SPECIALTY	NAME	SPECIALTY

Are you regularly taking vitamins, supplements or nonprescription medicines? ☐ Yes ☐ No

If yes, please list: _____

_____

Are you on a special diet? ☐ Yes ☐ No

If yes, why, and describe diet: _____

Do you always fasten your seat belt when you are in the car? ☐ Yes ☐ No

Do you protect yourself from the sun when you are outdoors? ☐ Yes ☐ No

Have your feelings interfered with your ability to interact socially with friends? ☐ Yes ☐ No

During the past two weeks, have you felt a lack of interest or pleasure in normal activities?

☐ No, not at all ☐ Yes, several days ☐ Yes, more than half of the days ☐ Yes, nearly every day

During the past two weeks, have you felt down, depressed or hopeless?

☐ No, not at all ☐ Yes, several days ☐ Yes, more than half of the days ☐ Yes, nearly every day

If you answered "No" to **both** of the last two questions, skip to the next page. If yes to either question, check the boxes below that most closely answer the question as it applies to the last two weeks:

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF OF THE DAYS	NEARLY EVERY DAY
Have you had trouble falling asleep, staying asleep or sleeping too much?	☐	☐	☐	☐
Have you been feeling tired or have little energy?	☐	☐	☐	☐
Have you had a poor appetite or have you been overeating?	☐	☐	☐	☐
Have you been feeling bad about yourself – or that you are a failure or have let yourself or family down?	☐	☐	☐	☐
Have you had trouble concentrating, such as reading the newspaper or watching television?	☐	☐	☐	☐
Have you been moving or speaking so slowly that other people could have noticed? Or the opposite – have you been so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
Have you had thoughts that you would be better off dead or of hurting yourself in some way?	☐	☐	☐	☐
If you have experienced any of the above, how difficult has it been for you to do your work, take care of things at home or get along with other people?	☐ Not difficult at all	☐ Somewhat difficult	☐ Very difficult	☐ Extremely difficult

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How often do you get the social and emotional support you need?

☐ Never or rarely ☐ Sometimes ☐ Often ☐ Always

In general, how satisfied are you with your life?

☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

In general, would you say your health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

How often is stress a problem for you?

☐ Never or rarely ☐ Sometimes ☐ Often ☐ Always

How well do you handle the stress in your life?

☐ Usually able to cope effectively ☐ At times have problems coping ☐ Often have problems coping

How many hours of sleep do you usually get each night? _____ hours

Do you have trouble hearing the television or radio when others do not? ..... ☐ Yes ☐ No

Do you have to strain to hear or understand conversations? ..... ☐ Yes ☐ No

Do you need help with preparing meals, using the phone, taking your medicine, managing your finances, transportation, shopping, or housework and laundry? ..... ☐ Yes ☐ No

Do you live alone? ..... ☐ Yes ☐ No

Does your home have throw rugs, poor lighting, or a slippery bathtub or shower? ..... ☐ Yes ☐ No

Does your home have grab bars in bathrooms or handrails on stairs and steps? ..... ☐ Yes ☐ No

Does your home have functioning smoke alarms? ..... ☐ Yes ☐ No

Have you executed an advance directive to a physician and family? ..... ☐ Yes ☐ No

Do you exercise regularly? ..... ☐ Yes ☐ No

Have you fallen in the past year? ..... ☐ Yes ☐ No

If yes, how many times have you fallen in the past year? _____

Are you afraid of falling? ..... ☐ Yes ☐ No

Have you accidentally leaked urine in the past six months? ..... ☐ Yes ☐ No

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

Pain Assessment

Please check the box which most accurately reflects your level of pain.

☐ 0. No pain

☐ 1. Some pain, but okay

☐ 2. Mild pain worse

☐ 3. Annoying pain

☐ 4. Distracting pain

☐ 5. Pain too bad to ignore for long

☐ 6. Pain can't be ignored at all

☐ 7. Pain makes it hard to think and sleep

☐ 8. Pain limits activity, nausea with pain

☐ 9. I cry out in pain

☐ 10. Passed out

Katz Index

For each activity, check independent or dependent.

ACTIVITY	INDEPENDENT	DEPENDENT
Bathing	☐ Bathes self completely or needs help in bathing only a single body area such as back, genital area or disabled extremity.	☐ Needs help with bathing more than a single body area, getting in or out of the tub or shower. Requires total bathing.
Dressing	☐ Gets clothes from closets and drawers and puts on clothes and outer garments with fasteners. May have help tying shoes.	☐ Needs help with dressing self or needs to be completely dressed.
Toileting	☐ Goes to the toilet, gets on and off, arranges clothes, cleans genital area without help.	☐ Needs help transferring to toilet, cleaning self or uses bedpan or bedside commode.
Transferring	☐ Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable.	☐ Needs help in moving from bed to chair or requires a complete transfer.
Continence	☐ Exercises complete self-control over urination and defecation.	☐ Is partially or totally incontinent of bowel or bladder.
Feeding	☐ Gets food from plate into mouth without help. Preparation of food may be done by another person.	☐ Needs partial or total help with feeding or requires parenteral feeding.

Patient Signature _____ Date _____