Family Care Physicians, P.C.
Anxiety and Depression Institute
MEDICARE ANNUAL WELLNESS QUESTIONNAIRE

PATIENT NAME:

PATIENT DOB:

TODAY'S DATE:

In general how would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Do you find it hard to control your bladder? ☐ Yes ☐ No ☐ Sometimes
Do you find it hard to control your bowels? ☐ Yes ☐ No ☐ Sometimes
Do you have difficulty hearing? ☐ Yes ☐ No ☐ Sometimes If yes, do you wear Hearing Aids? ☐ Yes ☐ No
Do you have difficulty with your eyesight? ☐ Yes ☐ No ☐ Sometimes If yes, do you wear Contacts or Glasses? ☐ Yes ☐ No When was your last eye exam:
Do you have any problems with your teeth or dentures? ☐ Yes ☐ No When was your last dentist appointment:
During the past 2 weeks has your physical or emotional health limited your social activities with family or friends? ☐ Yes ☐ No ☐ Sometimes
Is stress a problem for you in handling your health, finances, family relationships or other relationships? ☐ Yes ☐ No ☐ Sometimes
In the past for weeks how often have you experienced anger? ☐ Never ☐ Seldom ☐ Often
PAIN (1125F-Pain Present) or (1126F-No Pain Present)
Are you having pain today? ☐ Yes ☐ No
If yes, where is the pain located? Pain Level 1-10:

FALL RISK - (3288F)

Have you fallen in the last year? ☐ Yes ☐ No

If yes, how many times have you fallen?

Did the fall(s) result in injury? ☐ Yes ☐ No

If yes please describe:

Are you afraid of falling or do you feel unsteady when standing or walking?

☐ Yes ☐ No

Does furniture, rugs, cords or poor lighting present difficulty with getting around your house?

☐ Yes ☐ No

Are any of the stairs/steps in your house broken or uneven? ☐ Yes ☐ No

Do you use an assistive device to walk? ☐ Yes ☐ No

if yes, ☐ Cane ☐ Walker ☐ Wheelchair

FUNCTIONAL ABILITY, SAFETY, HOME & ENVIRONMENT (1170F)

Do you exercise for about 30 minutes on 5 or more days per week?

☐ Yes, most of the time ☐ Yes, some of the time ☐ No

Are you able to get in and out of cars? ☐ Yes ☐ No

Are you able to go down stairs? ☐ Yes ☐ No

Are you able to go up stairs? ☐ Yes ☐ No

In the last 7 days did you need help from others to perform any of the following everyday activities: eating, getting dressed, grooming, bathing, walking, or using the toilet?

☐ Yes ☐ No

In the last 7 days did you need help from others to take care of any of the following activities: laundry and housekeeping, banking, shopping, preparing food, transportation or taking your own medications?

☐ Yes ☐ No

Do you have smoke detectors in your home? ☐ Yes ☐ No

Do you use a seat belt in a vehicle? ☐ Yes ☐ No	
Do you have carbon monoxide detectors in your home? ☐ Yes ☐ No	
Do you have firearms? ☐ Yes ☐ No if yes, are the firearms stored securely? ☐ Yes ☐ No	
Do you follow a Healthy Diet? ☐ Yes ☐ No ☐ Explain:	
TOBACCO AND ALCOHOL	
Do you use tobacco? ☐ Yes ☐ No ☐ Former	
If Yes ☐ Cigarettes ☐ Vape ☐ Chew Amount:	
Do you drink alcohol? ☐ Yes ☐ No If yes, what types? (check all that apply) ☐ Beer ☐ Wine ☐ Hard Liqour	
How frequently do you drink alcohol? ☐ Daily ☐ Weekly ☐ Socially (< 1 drink per Month)	
How much alcohol do you think you drink at one time? ☐ 1-3 Drinks ☐ 4-6 Drinks ☐ 7 or more Drinks	
ADVANCE DIRECTIVES	
Do you have an Advanced Directive for Healthcare? ☐ Yes ☐ No If No, would you like more information ☐ Yes ☐ No	

HEALTH SCREEN HISTORY				
When was your last:				
Colonoscopy/Cologuard:	Date:		Where:	
Mammogram:	Date:		Where:	
Pap smear:	Date:		Where:	
Bone Density	Date:		Where:	

Family Care Physicians, P.C.
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Patient Health Questionnaire Depression (PHQ-9)

Date: Patient Name: Date of Birth:

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please click the check mark by your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0 ☐	1☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless.	0 ☐	1☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much.	0 ☐	1☐	2 ☐	3 ☐
4. Feeling tired or having little energy.	0 ☐	1☐	2 ☐	3 ☐
5. Poor appetite or overeating.	0 ☐	1☐	2 ☐	3 ☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0 ☐	1☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0 ☐	1☐	2 ☐	3 ☐
8. Moving or speaking slowly that others could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0 ☐	1☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0 ☐	1☐	2 ☐	3 ☐
Add the score for each column				

Total Score (add your column scores):

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Please check one)

☐ **Not difficult at all.** ☐ **Somewhat difficult.** ☐ **Very Difficult.** ☐ **Extremely Difficult.**

Anxiety and Depression Institute
Patient Health Questionnaire General Anxiety Disorder (GAD-7)

Date: | Patient Name: | Date of Birth:

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please click the check mark by your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0 ☐	1☐	2 ☐	3 ☐
2. Not being able to stop or control worrying.	0 ☐	1☐	2 ☐	3 ☐
3. Worrying too much about different things.	0 ☐	1☐	2 ☐	3 ☐
4. Trouble relaxing.	0 ☐	1☐	2 ☐	3 ☐
5. Being so restless that it's hard to sit still.	0 ☐	1☐	2 ☐	3 ☐
6. Becoming easily annoyed or irritable.	0 ☐	1☐	2 ☐	3 ☐
7. Feeling afraid as if something awful might happen.	0 ☐	1☐	2 ☐	3 ☐
Add the score for each column				

Total Score (add your column scores):

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Please check one)

☐ **Not difficult at all.** ☐ **Somewhat difficult.** ☐ **Very Difficult.** ☐ **Extremely Difficult.**

Social Determinants of Health

Patient Name: (first & last)

Patient Date of Birth:

Patient Primary Care Physician:

Today's Date:

As your Patient-Centered Medical Home, we are happy to partner with you, to help you and your family in time of need. From the answers below, we maintain a list of trusted community resources that care about you as much as we do.

Please answer the following questions.			
Within the past 12 months have you worried whether your food would run out before you got money to buy more?	☐ Often	☐ Sometimes	☐ Never
Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household?	☐ Yes	☐ No	
In the past year, has the utility company shut off your service for not paying your bills?	☐ Yes	☐ No	
In the last 12 months, did you skip medications to save money?	☐ Yes	☐ No	
In the last six months, have you ever had to go without health care because you didn't have a way to get there?	☐ Yes	☐ No	
Do problems getting child care or elderly care make it difficult to work or study?	☐ Yes	☐ No	
Do you need any assistance with finding a local career center or job training?	☐ Yes	☐ No	
I have trouble understanding my doctor's written instructions.	☐ Yes	☐ No	
How often do you feel lonely?	☐ Often	☐ Sometimes	☐ Never
Do you ever feel unsafe in your home or neighborhood?	☐ Yes	☐ No	
If you answered yes, would you like to receive assistance with any of these needs?	☐ Yes	☐ No	
Can we share this information with organization to whom we make referrals to address these needs	☐ Yes	☐ No	