FAMILY MEDICINE PARTNERS of Santa Fe

You are scheduled for your **Medicare Annual Wellness Visit** today. **Please enter information in the space provided or circle your answer**.

Please list all healthcare providers and specialists who you have seen in the past year:

Name of Provider	Specialty	Month Last Seen
1. Christus St. Vincent / Tricore / Quest (**circle**)	Lab	
2. Santa Fe Imaging / X-Ray Associates (**circle**)	Radiology Center	
3. _____	Eye Doctor	
4		
5		
6		

Have you been hospitalized in the last year? YES NO

How many servings of fruits and vegetables do you have per day? _____

How many times per week do you exercise? _____ Duration? _____ Type? _____

Do you have trouble hearing the TV or radio when others don't? YES NO

Do you have to strain or struggle to hear/understand conversations? YES NO

If so, do you wear hearing aids? YES NO

Do you need help with any of the following activities? (**Please check**)

❑ bathing	❑ grooming	❑ oral care	❑ dressing
❑ eating	❑ toileting	❑ continence	❑ transferring
❑ walking	❑ preparing meals	❑ transportation	❑ shopping
❑ housekeeping	❑ taking your meds	❑ managing finances	❑ _____

*** **Please see other side** ***

Do you live alone? YES NO

Have you had an injury from a fall in the last year? YES NO

Have you had more than one fall in the last year? YES NO

Does your home have rugs, poor lighting, or a slippery bathtub/shower? YES NO

Does your home have grab bars in bathrooms, handrails on stairs or steps? YES NO

Does your home have functioning smoke alarms? YES NO

Are you having difficulties driving your car? YES NO

Do you always fasten your seat belt when you are in a car? YES NO

Have you ever had a Zostavax or "Shingles Shot"? YES NO

If so, when? _____

Have you had a Flu Shot outside this office in the past year? YES NO

If so, when? _____ and where? _____

Please circle the number associated with your response:

Over the past two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than one-half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day _____

An Advance Healthcare Directive is a document that helps ensure that your health care wishes will be respected if you become unable to make your own decisions. May we discuss this topic with you? YES NO

If so, do you have a written Advanced Health Care Directive? YES NO

Where is it located? _____

***** Thank You *****