Annual Wellness Visit (AWV) **Questionnaire**

Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

HQIN Health Quality Innovation Network

Name:	Date of birth:

Please fill this out and bring it to your Annual Wellness Visit.

The names of all your doctors, including specialists, chiropractors, eye doctor and counselors:	
Name	Specialty

Please bring all your medications so we can review them with you, including vitamins, herbs, and supplements:		
Medication Name	Dose	How Often You Take It

Pharamacies and Medical Equipment Providers:	
Name of Pharmacy	**Location**
Name of Medical Equipment Company	**Equipment Supplied**

Do you receive home health care or use medical equipment at home? (ex: oxygen)	☐ Yes ☐ No
Have any of your close relatives had any recent health changes?	☐ Yes ☐ No
Have you received any recent immunizations at a location other than our office?	☐ Yes ☐ No
Have you had a preventive test recently done, such as a mammogram or colonoscopy?	☐ Yes ☐ No
Are you worried about your memory?	☐ Yes ☐ No
Do you worry about falling?	☐ Yes ☐ No
Do you have an advance directive? (a health care proxy, living will, DNR, MOLST)?*	☐ Yes ☐ No

*If you have already completed an advance directive, please bring it with you so we may include a copy of the document in your health record.

Please list any health GOALS you would like to discuss at your Annual Wellness Visit.
ex: I'd like to be able to go on a 20-30 minute walk every day.

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