Annual Wellness Summary

Patient Information

Name: _____ DOB: _____

Primary Insurance: _____ Secondary Insurance: _____

Emergency Contact: _____ Phone: _____

Directions

This packet helps you prepare for your Medicare Annual Wellness Visit. Fill out what you know and bring it with you. Use it to track lifestyle information, equipment and safety needs, vitals, specialists, hospitalizations, surgeries, chronic conditions, medications, allergies, pharmacies, vaccines, preventive screenings, and advance care planning. It's okay to leave blanks—your provider can review the rest with you.

Lifestyle Snapshot

Smoking (packs/day): _____ Alcohol (how much/often): _____

Exercise (days/week): _____ Walk? _____ Strengthening? _____ Other? _____

Sleep hrs/night: _____ CPAP? Y/N Hearing Aids? Y/N

Mood (1-10): _____ Pain (1-10): _____

Falls in last 12 mos: Y/N Injury? Y/N Balance/Dizziness? Y/N

Unintentional weight loss (6 mos): Y/N Poor appetite: Y/N

Chewing/swallowing problems: Y/N Dentures: Y/N

Durable Medical Equipment (Current or Desired)

Cane: Y/N Grab Bars: Y/N

Walker: Y/N Shower Chair: Y/N

Wheelchair: Y/N Raised Toilet Seat: Y/N

Scooter: Y/N Hospital Bed: Y/N

CPAP: Y/N Lift Chair: Y/N

Oxygen: Y/N Life Alert/Emergency Alert: Y/N

Daily Living & Safety Concerns

Trouble with Food/Meals: Y/N Trouble with Bathing/Dressing: Y/N

Trouble with Transportation: Y/N Trouble with Medication Mgmt: Y/N

Trouble with Housekeeping/Cleaning: Y/N Trouble with Finances/Phone Use: Y/N

Supportive Services

Home Health: Y/N Meals on Wheels: Y/N

Personal Care Aide: Y/N Transportation Program: Y/N

Senior Center/Day Program: Y/N PT/OT: Y/N

Palliative Care/Hospice: Y/N

Quick Vitals

Date	Blood Pressure	Blood Sugar	Oxygen	Weight

Specialists & Providers

Provider	Specialty	Last Visit	Seen For	Next Visit

Hospitalizations (past 12 months)

Date	Reason	Facility

Vaccines

Vaccine	Date(s)	Next Due
Flu		
Pneumonia		
Shingles		
COVID		
Tetanus		
RSV		
Other		

Preventive Screenings

Screening	Last Date	Next Due
Colonoscopy		
Mammogram		
Bone Density (DEXA)		
Eye Exam		
Glasses (Y/N; Readers/Prescription)		
Dental Exam		
Hearing Test		
Hearing Aids (Y/N)		
Low-dose CT (Lung)		
AAA Ultrasound		
Other		

Advance Care Planning

Advance Directive on file? Y/N	
POLST on file? Y/N	
Healthcare Proxy/POA:	Phone:

Past Surgeries

Surgeon/Facility	Surgery	Date	Outcome/Notes

Chronic Conditions

Diagnosis	Date Diagnosed	Notes

Medications

Medication	Dosage	Frequency	Reason

Allergies

Allergy	Reaction/Notes

Pharmacy

Local Pharmacy	
Mail Order Pharmacy	