Medicare Wellness Checkup

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

1. What is your age?
☐65-69 ☐70-79. ☐ 80 or older.

2. Are you a male or a female?
☐Male. ☐Female.

2A. Occupation

_____

3. During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?
☐Not at all.
☐Slightly.
☐Moderately.
☐Quite a bit.
☐Extremely.

4. During the past four weeks, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?
☐Not at all.
☐Slightly.
☐Moderately.
☐Quite a bit.
☐Extremely.

5. During the past four weeks, how much bodily pain have you generally had?
☐No pain.
☐Very mild pain.
☐Mild pain.
☐Moderate pain.
☐Severe pain.

6. During the past four weeks, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)
☐Yes, as much as I wanted.
☐Yes, quite a bit.
☐Yes, some.
☐Yes, a little.
☐No, not at all.

7. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?
☐Very heavy.
☐Heavy.
☐Moderate.
☐Light.
☐Very light.

Your name:

_____

Today's date:

_____

Your date of birth:

_____

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)
☐Yes. ☐No.

9. Can you go shopping for groceries or clothes without someone's help?
☐Yes. ☐No.

10. Can you prepare your own meals?
☐Yes. ☐No.

11. Can you do your housework without help?
☐Yes. ☐No.

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
☐Yes. ☐No.

13. Can you handle your own money without help?
☐Yes. ☐No.

14. During the past four weeks, how would you rate your health in general?
☐Excellent.
☐Very good.
☐Good.
☐Fair.
☐Poor.

15. How have things been going for you during the past four weeks?
☐Very well; could hardly be better.
☐Pretty well.
☐Good and bad parts about equal.
☐Pretty bad.
☐Very bad; could hardly be worse.

16. Are you having difficulties driving your car?
☐Yes, often.
☐Sometimes.
☐No.
☐Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?
☐Yes, usually.
☐Yes, sometimes.
☐No.

Continued➔

18. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up					
Sexual problems					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					
Tiredness or fatigue					

19. Have you fallen two or more times in the past year?
☐Yes. ☐No.

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

20A. Are there loose carpets, poor lighting, or lack of handrails on stairs, or lack of grab bars in bathrooms?
☐Yes. ☐No.

21. Are you a smoker?
☐No.
☐Yes, and I might quit.
☐Yes, but I'm not ready to quit.

21A. Caffeine consumption?
☐Never.
☐Occasional.
☐Daily.

22. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?
☐10 or more drinks per week.
☐6-9 drinks per week.
☐2-5 drinks per week.
☐One drink or less per week.
☐No alcohol at all.

22A. Drug Abuse?
☐Never.
☐Occasional.
☐Daily.
☐Prior Use. Quit date _____

23. Do you exercise for about 20 minutes three or more days a week?
☐Yes, most of the time.
☐Yes, some of the time.
☐No, I usually do not exercise this much.

Your name:
_____
Today's date:
_____
Your date of birth:
_____

24. Have you been given any information to help you with the following:
Hazards in your house that might hurt you?
☐Yes. ☐No.
Keeping track of your medications?
☐Yes. ☐No.

25. How often do you have trouble taking medicines the way you have been told to take them?
☐I do not have to take medicine.
☐I always take them as prescribed.
☐Sometimes I take them as prescribed.
☐I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?
☐Very confident.
☐Somewhat confident.
☐Not very confident.
☐I do not have any health problems.

26A. Do you have a Living Will…
☐Yes or ☐No
or Advance Medical Directive?
☐Yes or ☐No

26B. Would you like information about Living Wills or Advance Medical Directives?
☐Yes or ☐No

27. What is your race? (Check all that apply.)
☐White.
☐Black or African American.
☐Asian.
☐Native Hawaiian or other Pacific Islander.
☐American Indian or Alaskan Native.
☐Hispanic or Latino origin or descent.
☐Other.

27A. Home Environment?
☐Private Home.
☐Assisted Living.
☐Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

PATIENT PACKET PAGE 2

NAME _____ DATE OF BIRTH _____

MEDICARE ANNUAL WELLNESS VISIT/PREVENTIVE PHYSICAL FORM PERTINENT HISTORY

TODAY'S DATE _____

Family History – Use ✓ to indicate positive history									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart Disease									
Stroke									
Kidney Disease									
Obesity									
Genetic Disorder									
Alcoholism									
Liver Disease									
Depression or Manic Depressive Disorder									
Colon/Rectal Cancer									
Breast Cancer									
Other Cancer									
Other_____									

Medical History				
Hospital Visits since last office visit/reason	Facility	Attending Physician	Date of Hospital Visit	Past Surgeries (include dates and complications if any)

Other Physicians and Providers of Care		
Name & Specialty/Provider Type	Type of Care	Date discontinued

Problem List				
Chronic Problems	Date added	Managing Physician (if other)	Date Updated	Initial

My Pharmacy:_____

Name Last_____First_____M.I._____D.O.B._____
Address_____Home Phone_____❑
City/State/Zip_____ Cell Phone_____❑
Work Phone_____❑

❑**Please check the box above if we may leave personally identifiable health information on this phone number**

Medication Allergies/Intolerance/Adverse Reactions
_____
_____

↓↓SECTION BELOW FOR PATIENT TO FILL OUT

↓↓SECTION BELOW FOR OFFICE USE ONLY

ACTIVE MEDICATIONS (including Prescriptions, OTC, Supplements, Herbals, and ANY "as needed" [prn] meds)				**Today's Date / Initials (✓ active drugs or d/c)**									
Drug Name	***Dose***	***Instruction***	***Prescribing Doctor***										

PATIENT PACKET PAGE 4 (03/12)