Your name:_____

Today's date:_____

Your date of birth:_____

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

3. During the past four weeks, how much bodily pain have you generally had?

☐No pain
☐Very mild pain
☐Mild pain
☐Moderate pain
☐Severe pain

4. 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

5. 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

6. 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

7. Can you go shopping for groceries or clothes without someone's help?

☐Yes ☐No

8. Can you prepare your own meals?

☐Yes ☐No

9. Can you do your housework without help?

☐Yes ☐No

10. 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

11. Can you handle your own money without help?

☐Yes ☐No

12. During the past four weeks, how would you rate your health in general?

☐Excellent
☐Very good
☐Good
☐Fair
☐Poor

13. 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

14. Are you having difficulties driving your car?

☐Yes, often
☐Sometimes
☐No
☐Not applicable, I do not use a car

15. Do you always fasten your set belt when you are in a car?

☐Yes, usually
☐Yes, sometimes
☐No

Continued on next page

16. Have you fallen 2 or more times in the past year?
☐Yes ☐No

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

18. Are you a smoker?
☐Yes ☐No

19. During the past 4 weeks how many drinks of wine/beer/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

20. Do you exercise for about 20 minutes 3 or more days a week?
☐Yes ☐No

21. How often do you have trouble taking medications the way you have been instructed to take them?
☐I do not take medicine
☐Ialways take them as prescribed
☐I sometimes take them as prescribed
☐I seldom take them as prescribed

22. How confident are you that you can control and manage most of your health problems?
☐Very confident
☐Not very confident

Name:_____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

		Not at all	Several Days	More than half the days	Nearly Everyday
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 so slowly that other people 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 Columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to instructions on tear-off pad cover

TOTAL =

10	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all Somewhat difficult Very difficult Extremely difficult

Provider Signature Typing your name above qualifies as your signature

Date

Alcohol Screen (Cage)

1. **Have you ever felt you needed to cut down on your drinking?**
   ☐ **Yes** ☐ **No**
2. **Have people annoyed you by criticizing your drinking**
   ☐ **Yes** ☐ **No**
3. **Have you ever felt guilty about drinking?**
   ☐ **Yes** ☐ **No**
4. **Have you ever felt you needed a drink first thing in the morning to calm you?**
   ☐ **Yes** ☐ **No**

How often per week do you eat fruits, vegetables or cereals?
☐Everyday
☐Most days
☐Rarely

In the past 2 weeks how often have you felt nervous, anxious, or on edge?
☐All the time
☐Most of the time
☐Sometimes
☐Never

How often does stress interfere with your daily activities? (ex. paying bills, family, social or health issues)
☐Never
☐Sometimes
☐Often
☐Rarely

Each night how many hours of sleep do you get?
_____hours

Do you snore, or has anyone told you you snore?
☐Yes
☐No

Do you feel sleepy during the daytime?
☐Always
☐Usually
☐Sometimes
☐Rarely

Do you have any problems with urinary incontinence?
☐Yes
☐No

Do you have a living will?
☐Yes
☐No

Do you have a surrogate decision maker?

_____

In the past 10 years have you had any of the following VACCINES?
(Approximate date and place if not given here)

Influenza:_____

Prevnar 13: _____

Pneumovax 23:_____

Tdap:_____

Shingles: _____

Thank you for completing the health risk assessment questionnaire