Medicare Wellness Visit

Please complete checklist before your seeing your healthcare provider. Your responses will help you receive the best health and health care possible.

Your Name: _____

Today's Date: _____

Your date of birth: _____

DEMOGRAPHICS

1. How old are you?

2. Ethnicity – circle one
Non-Hispanic white
Hispanic
Black/African American
Asian/Asian American

3. Marital status – circle one

Married	Widowed
Single	Divorced

4. Employment status – circle one

Retired	Disabled
Employed	Self-employed
Home-maker	

5. How many children do you have?

RISK ASSESSMENT

6. Do you currently use tobacco products?
(if no proceed to question #11)

7. Have you ever used tobacco products?
- Yes, within the past 6 months
- Yes, more than 6 months ago
- Yes, more than 2 years ago
- No

8. What type of tobacco do you use or have you used?
- Chewing Tobacco
- Cigarettes
- Cigars
- Pipe Tobacco

9. (If cigarette smoker) How long have you smoked?
- 0-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- >20 years

10. (If cigarettes) How many cigarettes do you smoke per day?
- 10 or fewer
- 11-20
- 21-30
- 31 or more

11. How many alcoholic beverages (i.e 1oz hard liquor, one glass of wine, one bottle of beer) do you drink, on average?
(if none continue to question #16)
- None
- 1-2 per month
- 1-2 per week
- 1-2 daily
- 3-4 daily
- 5-6 daily
- More than 6 daily

12. Have you ever felt the need to cut down on drinking?
- Yes
- No

13. Have people annoyed you with criticism of your drinking?
- Yes
- No

14. Do you or have you felt guilty for drinking?
- Yes
- No

15. Have you ever felt the need to drink first thing in the morning to steady your nerves or get rid of a hangover?
- Yes
- No

16. How often do you exercise?
- Never
- Rarely
- Often
- Daily

17. How vigorously can you exercise?
- Not at all
- Minimally
- Moderately
- Very Vigorously

18. How often do you use seatbelts?
- Never
- Sometimes
- Most of the time
- Always

MENTAL HEALTH ASSESSMENT

19. In the past 2 weeks, how often have you felt depressed, down or hopeless?
- Never
- Rarely
- More than half of the days
- Every day

20. In the past month, how often have you felt anxious or stressed?
- Never
- Rarely
- More than half of the days
- Every day

21. What is your average level of daily stress?
- None
- Low
- Mild
- Moderate
- High

22. In the past 2 weeks, how often have you felt a lack of pleasure or interest in doing things?
- Never
- Rarely
- More than half of the days
- Every day

23. In the past 2 weeks, how often have you had difficulty falling asleep or episodes of sleeping too long?
- Never
- Rarely
- More than half of the days
- Every day

24. In the past 2 weeks how often have you had a lack of energy?
- Never
- Rarely
- More than half of the days
- Every day

25. In the past 2 weeks, how often have you had feelings of being better off dead or thoughts of harming yourself?
- Never
- Rarely
- More than half of the days
- Every day

26. Have you ever attempted to harm yourself?
- Yes
- No

GENERAL HEALTH/PAIN ASSESSMENT

27. In the past month, how often did you experience pain?
- Never
- Rarely
- Frequently
- Most days
- Daily

28. In the past month, how much has pain affected your ability to work?
- Not at all
- A little
- To a moderate degree
- To an extreme degree

29. In the past month, how much has pain affected your ability to walk?
- Not at all
- A little
- To a moderate degree
- To an extreme degree

30. In the past month, how much has pain affected your relationship with other people?
- Not at all
- A little
- To a moderate degree
- To an extreme degree

31. On a scale of 1-10, how bad would you rate your average daily pain?

32. How would you describe the ease with which you can prepare your own food?
- Very easy
- Easy
- A little difficult
- Somewhat difficult
- Very difficult
- I can't prepare my own food

33. How would you describe the ease with which you can bathe or clean yourself?
- Very easy
- Easy
- A little difficult
- Somewhat difficult
- Very difficult
- I can't bathe or clean myself

34. How would you describe the ease with which you can dress yourself?

- Very easy
- Easy
- A little difficult
- Somewhat difficult
- Very difficult
- I can't dress myself

35. How hard is it to use the toilet by yourself?

- Not hard at all
- Somewhat hard
- A little hard
- Very Hard

36. How would you describe the ease with which you can do your own shopping?

- Very easy
- Easy
- A little difficult
- Somewhat difficult
- Very difficult
- I can't do my own shopping

37. How would you describe the ease with which you can get around your house?

- Very easy
- Easy
- A little difficult
- Somewhat difficult
- Very difficult
- I can't get around the house at all without assistance

38. How would you describe your ability to pay your bills?

- Very good
- Good
- Adequate
- Poor
- Very poor

39. How would you describe your ability to plan your daily and monthly budget?

- Very good
- Good
- Adequate
- Poor
- Very poor

40. How would you describe your ability to do routine housework?

- Very good
- Good
- Adequate
- Poor
- Very poor

HOME SAFETY/ASSISTANCE

41. Do you feel like you are safe in your current home?
- Yes
- No

42. How many times have you fallen in your home in the past year?
- Never
- Once
- A few times
- Many times
- All the time

43. How much would you need to change your living circumstances to feel safe?
- Not at all
- A little
- Quite a bit
- A significant amount

44. Do you feel living somewhere else would be good for you?
- Yes
- No

45. How much help do you feel you need at home?
- None at all
- A little
- Quite a bit
- A significant amount

46. How much does your family help with daily or routine chores?
- None at all
- A little
- Quite a bit
- A significant amount

47. Do you have an Advanced Directive (Living Will)?
- Yes
- No

48. If you do not have an Advanced Directive (Living Will), are you interested in finding out more information on this?
- Yes
- No

Wellness Questionnaire **Name:**	**Date:**
List all your doctors and medical providers	Specialty

List all your medications, including non-prescription meds	Dose/Strength	Frequency
Have you had any preventive health tests done recently?	Yes()	No()
Have you had any recent immunizations?	Yes()	No()
Has your mood changed recently?	Yes()	No()
Are you worried about falling?	Yes()	No()
Are you concerned about your memory?	Yes()	No()
Do you have a Living Will or Advance Directive?	Yes()	No()