**Updated 10/24/2021**

**MEDICARE WELLNESS CHECKUP** Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today's date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete this checklist before seeing Your date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

your doctor or nurse. Your responses will

help you receive the best health and health

care possible.

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| 1. Have you noticed any trouble with your hearing?  □ Yes □ No  2. Have you been told by others that you have a hearing problem?  □ Yes □ No    3. Check any of the following you can do without assistance:  □ Bathing □ Dressing  □ Toileting  □ Transfers □ Continence  □ Feeding    4. Home safety checklist  Do you have adequate housing? □ Yes □ No  Do you have transportation? □ Yes □ No  Do you have sufficient food? □ Yes □ No  Do you have access to a phone? □ Yes □ No  Do you feel safe at home? □ Yes □ No  Actual threats of physical or  emotional abuse? □ Yes □ No  Actual threats of sexual abuse? □ Yes □ No  5. Do you have any of the following?  □ None □ Living Will □ POLST □ Durable POA    11. During the past **four weeks,** what was  hardest physical activity you could do for at least **two** minutes?  □ Very heavy □ Heavy □ Moderate  □ Light □ Very Light  12. 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    13. Can you go shopping for groceries  or clothes without someone's help?  □ Yes □ No    14. Can you prepare your own meals?  □ Yes □ No    15. Can you do your housework without help?  □ Yes □ No    16. 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  17. Can you handle your own money without  help?  □ Yes □ No  18. During the past **four weeks**, how would you rate your health in general?  □ Excellent □ Very good □ Good  □ Fair □ Poor  19. 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  26. During the last **four weeks,** how many drinks of wine, beer, or 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    27. Do you exercise 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    28. Have you been given any information to help with the following:  Hazards in your house that might hurt you?  □ Yes □ No  Keeping track of your medications?  □ Yes □ No  29. How often do you have trouble  □ I do not have to take medications  □ I always take them as prescribed  □ Sometimes I take them as prescribed  □ I seldom take them as prescribed  30. 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 | 6. What is your race? (Check all that apply)  □ White □ Black or African American □ Asian □ Native Hawaiian or Pacific Islander □ American Indian or Alaskan Native □ Hispanic or Latino origin or descent  □ Other  7. During the past **four weeks,** how much have you been bothered by emotional problem such as feeling anxious, irritable, sad, or down-  hearted and blue?  □ Not at all □ Slightly □ Moderately □ Quite a bit □ Extremely  8. During the last **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  9. During the last **four weeks,** how much bodily  pain have you generally had?  □ No pain □ Very mild pain □ Mild pain □ Severe pain  10. During the last **four weeks,** was someone  available to help you if you needed and wanted  help?  □ Yes, as much as I wanted . □ Yes, quite a bit □ Yes, some  □ Yes, a little □ No, not at all  20. Are you having trouble driving your car  □ Yes, often □ Sometimes  □ No □ Not applicable, I do not use a car  21. Do you always fasten your seat belt in a car?  □ Yes, usually □ Yes, sometimes □ No  22. How often in the past four weeks have you been bothered by any of the following?  Falling or dizzy when stand up:  □ Never □ Seldom □ Sometimes  □ Often □ Always  Sexual Problems:  □ Never □ Seldom □ Sometimes  □ Often □ Always  Trouble eating well:  □ Never □ Seldom □ Sometimes  □ Often □ Always  Teeth or denture problems:  □ Never □ Seldom □ Sometimes  □ Often □ Always  Problems using the telephone:  □ Never □ Seldom □ Sometimes  □ Often □ Always  Tiredness or fatigue:  □ Never □ Seldom □ Sometimes  □ Often □ Always  23. Have you fallen two or more times in **the past year**?  □ Yes □ No    24. Are you afraid of falling?  □ Yes □ No  25. Are you a smoker?  □ No □ Yes, and I might quit  □ Yes, but I am not ready to quit. |