**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 □ No2. 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 checklistDo you have adequate housing? □ Yes □ NoDo you have transportation? □ Yes □ NoDo you have sufficient food? □ Yes □ NoDo you have access to a phone? □ Yes □ NoDo you feel safe at home? □ Yes □ NoActual threats of physical oremotional abuse? □ Yes □ NoActual threats of sexual abuse? □ Yes □ No5. Do you have any of the following?□ None □ Living Will □ POLST □ Durable POA 11. During the past **four weeks,** what washardest physical activity you could do for at least **two** minutes?□ Very heavy □ Heavy □ Moderate□ Light □ Very Light12. 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 □ No17. Can you handle your own money without  help?□ Yes □ No18. During the past **four weeks**, how would you rate your health in general?□ Excellent □ Very good □ Good□ Fair □ Poor19. 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 worse26. 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 prescribed30. 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 □ Extremely8. 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 □ Extremely9. During the last **four weeks,** how much bodilypain have you generally had? □ No pain □ Very mild pain □ Mild pain □ Severe pain10. 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 all20. 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 □ AlwaysSexual Problems:□ Never □ Seldom □ Sometimes□ Often □ AlwaysTrouble eating well:□ Never □ Seldom □ Sometimes□ Often □ AlwaysTeeth or denture problems:□ Never □ Seldom □ Sometimes□ Often □ AlwaysProblems using the telephone:□ Never □ Seldom □ Sometimes□ Often □ AlwaysTiredness or fatigue:□ Never □ Seldom □ Sometimes□ Often □ Always23. Have you fallen two or more times in **the past year**?□ Yes □ No 24. Are you afraid of falling?□ Yes □ No25. Are you a smoker?□ No □ Yes, and I might quit□ Yes, but I am not ready to quit.  |