Patient Name:_____ **Date of Birth** ___/___/___

Date:_____

MEDICARE WELLNESS ANNUAL VISIT PATIENT *Checklist*

Please complete before seeing your provider.
Your answers will help you receive the best health care possible.

1. 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	
2. 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	
3. Do you exercise for about 20 minutes 3 or more days a week?	☐ Yes, most of the time ☐ Yes, some of the time ☐ No, I usually do not exercise this much.	
DURING THE PAST MONTH: 4. How would you rate your health in general?	☐ Excellent ☐ Good ☐ Fair ☐ Poor	
5. What was the hardest physical activity you could do for at least 2 minutes?	☐ Heavy ☐ Moderate ☐ Light	
6. How much bodily pain have you generally had?	☐ No pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain	
7. Has your physical and emotional health limited your social activities with family, friends, neighbors or groups?	☐ Not at all ☐ Slightly ☐ Quite a bit ☐ Extremely	
8. Is someone available to help you if you need or want help? For example, if you feel very nervous or lonely, get sick and had to stay in bed, need help with daily chores or taking care of yourself.	☐ Yes, as much as I wanted ☐ Yes, some ☐ Yes, a little ☐ No, not at all	
9. Can you get places without help? For example, can you travel alone by bus, taxi, or drive your own car?	☐ Yes	☐ No
10. Do you always fasten your seat belt when you are in a car?	☐ Yes	☐ No
11. Can you shop for groceries or clothes without help?	☐ Yes	☐ No
12. Can you prepare your own meals?	☐ Yes	☐ No
13. Can you do your own housework without help?	☐ Yes	☐ No
14. Can you handle your own money without help?	☐ Yes	☐ No

Patient Name:_____ **Date of Birth** ____/___/___

Date:_____

15. Do you need help eating, bathing, dressing, or getting around your home?	☐ Yes	☐ No
16. Are you afraid of falling?	☐ Yes	☐ No
17. Have you fallen with our without injury in past year ?	☐ Yes	☐ No
18. Have you noticed VISION loss over the past year?	☐ Yes	☐ No
19. Have you noticed MEMORY loss over the past year?	☐ Yes	☐ No
20. Have you noticed HEARING loss over the past year?	☐ Yes	☐ No
21. Have you been given any information to help you with the following:		
a) Hazards in your house that might hurt you?	☐ Yes	☐ No
b) Keeping track of your medications?	☐ Yes	☐ No
22. ADVANCED CARE DIRECTIVES		
a) Do you have a living will?	☐ Yes	☐ No
b) Do you have a health care proxy and power of attorney?	☐ Yes	☐ No
23. Have you been bothered by teeth or dentures?	☐ Yes	☐ No

24. Please circle if your FAMILY has had any of the following conditions:

Alcoholism Arthritis Cancer Diabetes Obesity Rheumatoid Arthritis

Seizures Stroke Heart Disease Kidney Disease Thyroid Disease

Other (please indicate):

25. **IMMUNIZATION STATUS REVIEW**

Have you ever had:

Tetanus Booster (in the last 10 years)?	☐ Yes	☐ No	☐ Can't Recall
Influenza Vaccine (this year)?	☐ Yes	☐ No	☐ Can't Recall
Pneumonia Vaccine (ever)? Date __/___/____ Circle: Prevnar or Pneumovax	☐ Yes	☐ No	☐ Can't Recall
Herpes Zoster vaccine (once)	☐ Yes	☐ No	☐ Can't Recall
Varicella (or ever had chicken pox)?	☐ Yes	☐ No	☐ Can't Recall

26. **SUPPLEMENTS**

Do you take the following:

Calcium	☐ Yes	☐ No
Vitamin D	☐ Yes	☐ No
Multivitamin	☐ Yes	☐ No
Folic Acid	☐ Yes	☐ No
Other:	☐ Yes	☐ No

Patient Name:_____ Date of Birth ____/ ___/ ___

Date:_____

27. **SPECIALISTS regularly involved with care**

28. **ALCOHOL USE REVIEW CAGE Questions**

During the past month, how many drinks of wine, beer or other alcoholic beverages did you have? ☐ More than 10 ☐ 5 - 10 ☐ Less than 5 ☐ No alcohol at all			
If you drink alcohol:			
Have you ever felt that you ought to cut down on your drinking?	☐ Yes	☐ No	☐ N/A
Have people annoyed you by criticizing your drinking?	☐ Yes	☐ No	☐ N/A
Have you ever felt guilty about drinking?	☐ Yes	☐ No	☐ N/A
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes	☐ No	☐ N/A

29. **DRUG use:**

Do you use IV drugs, marijuana, cocaine, or other drugs?_____	☐ Yes	☐ No

30. **TOBACCO use:**

Have you recently used tobacco?	☐ Yes	☐ No	☐ N/A
Have you used a smokeless tobacco product?	☐ Yes	☐ No	☐ N/A
If Yes to either - Would you be interested in quitting tobacco use within the next month?	☐ Yes	☐ No	☐ N/A

Patient Name:_____ Date of Birth ___/___/___

Date:_____

Patient Mood Survey

31. **Patient Health Questionnaire (PHQ9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (please circle your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things?	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless?	**0**	**1**	**2**	**3**
Trouble falling asleep, or are you sleeping too much?	**0**	**1**	**2**	**3**
Feeling tired or have little energy?	**0**	**1**	**2**	**3**
Poor appetite or overeating?	**0**	**1**	**2**	**3**
Feeling bad about yourself – or feeling you are a failure or have let your family down?	**0**	**1**	**2**	**3**
Trouble concentrating on things, such as reading or watching TV?	**0**	**1**	**2**	**3**
Moving or speaking so slowly that other people have noticed or the opposite- being so fidgety or restless that you have been moving around more than usual?	**0**	**1**	**2**	**3**
Thoughts that you would be better off dead, or of hurting yourself in some way?	**0**	**1**	**2**	**3**

For office coding (add columns): _____+_____+_____+ _____

Total =

If you circled off any problem, 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 Somewhat difficult Very difficult Extremely difficult

Thank you very much for completing your Medicare Wellness Checkup.
Please give the completed checklist to your provider.

Review of Systems (Please check the following for symptoms now present)

Patient Name (**please print**) _____ DOB _____Date_____

General:
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Excessive Fatigue
- ☐ Unintentional Weight Gain
- ☐ Unintentional Weight Loss
- ☐ Other _____

Eyes:
- ☐ Use Glasses/Contacts
- ☐ Blurry Vision
- ☐ Eye Pain
- ☐ Pain Looking at Bright Lights
- ☐ Other _____

Ear/Nose/Throat:
- ☐ Hearing Problems
- ☐ Ear Pain
- ☐ Nasal Congestion
- ☐ Runny Nose
- ☐ Nose Bleeds
- ☐ Mouth Sores
- ☐ Tooth Pain
- ☐ Sore Throat
- ☐ Voice Change
- ☐ Other _____

Cardiovascular:
- ☐ Chest Pain at Rest
- ☐ Chest Pain with Exertion
- ☐ Heart Fluttering
- ☐ Swollen feet or ankles
- ☐ Other _____

Respiratory:
- ☐ Recent Cough
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Pain with Breathing
- ☐ Coughing Up Blood
- ☐ Wheezing
- ☐ Other _____

Gastrointestinal:
- ☐ Abdomen Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Loss of appetite
- ☐ Heartburn/Acid Reflux
- ☐ Trouble swallowing
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Other _____

Genitourinary:
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Difficulty Controlling Urine
- ☐ Painful Menses
- ☐ Irregular Menstrual Cycle
- ☐ Heavy Menstrual Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Post-Menopausal Vaginal Bleeding
- ☐ Other _____

Musculoskeletal:
- ☐ New Joint Pains
- ☐ Joint Stiffness
- ☐ Back Pain
- ☐ Muscle Aches
- ☐ Other _____

Skin/Breast:
- ☐ Rashes
- ☐ Unusual Moles
- ☐ Breast Changes
- ☐ Other _____

Neurologic:
- ☐ Headaches
- ☐ Dizziness
- ☐ Weakness
- ☐ Numbness/Tingling
- ☐ Loss of Coordination
- ☐ Fainting
- ☐ Seizures
- ☐ Tremor
- ☐ Memory Loss
- ☐ Other _____

Blood/Lymphatic:
- ☐ Easy Bruising
- ☐ Excessive Bleeding
- ☐ Swelling at the Neck
- ☐ Other _____

Endocrine:
- ☐ Difficulty Maintaining a Comfortable Temperature
- ☐ Hot Flashes
- ☐ Excessive Sweating
- ☐ Changing Skin Color
- ☐ Hair loss
- ☐ Infertility
- ☐ Other _____

Allergic/Immunologic:
- ☐ Seasonal Allergies
- ☐ Hives
- ☐ Other _____

Psychiatric:
- ☐ Excessive Sadness
- ☐ Excessive Stress/Anxiety
- ☐ Mood Swings
- ☐ Poor Concentration
- ☐ Significant Trouble Sleeping
- ☐ Suicidal Thoughts
- ☐ Other _____

Social:

Do you smoke_____ Packs per day_____ # of years_____

Do you drink alcohol_____ Drinks per week_____ # of years _____

How many cups of caffeine (coffee/tea/soda) do you drink each day _____

What physical exercise or sports do you participate in regularly_____