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

Review of Systems (Please check the following for symptoms <u>now present</u>)

Patient Name (please print)_____DOB_____Date_____

General:
- ☐ Fever
- ☐ Unintentional Weight Gain
- ☐ Unintentional Weight Loss
- ☐ Chills
- ☐ Fatigue/Malaise
- ☐ Other_____

Eyes:
- ☐ Vision Changes
- ☐ Eye Irritation
- ☐ Other_____

Ears/Nose/Throat:
- ☐ Difficulty Hearing
- ☐ Ear Pain
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Teeth Problems
- ☐ Other_____

Cardiovascular:
- ☐ Chest Pain
- ☐ Heart Fluttering
- ☐ Swollen Feet or Ankles
- ☐ Other_____

Respiratory:
- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Other_____

Gastrointestinal:
- ☐ Abdomen Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Loss of Appetite
- ☐ Diarrhea
- ☐ Vomiting Blood
- ☐ Reflux
- ☐ Other_____

Genitourinary:
- ☐ Difficulty Controlling Urine
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Other_____

Women
- ☐ Painful Menses
- ☐ Irregular menstrual Cycle
- ☐ Vaginal Discharge

Musculoskeletal:
- ☐ Muscle Aches
- ☐ Joint Pains
- ☐ Back Pain
- ☐ Other_____

Skin/Breast:
- ☐ Unusual Moles
- ☐ Rashes
- ☐ Breast Changes
- ☐ Other_____

Neurologic:
- ☐ Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Headaches
- ☐ Tremor
- ☐ Other_____

Psychiatric:
- ☐ Excessive Sadness
- ☐ Significant Trouble Sleeping
- ☐ Anxiety
- ☐ Suicidal Thoughts
- ☐ Memory Loss
- ☐ Other_____

Endocrine:
- ☐ Intolerance to Cold/Heat
- ☐ Excessive Hair Loss
- ☐ Other_____

Blood/Lymphatic:
- ☐ Swollen Glands
- ☐ Easy Bruising
- ☐ Excessive Bleeding
- ☐ Other_____

Allergic/Immunologic:
- ☐ Sinus Pressure
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ 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_____

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.

Risk for Falls Survey

BeSafe!

Name_____

Please circle "Yes" or "No" for each statement below.			Why it matters
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
Total _____		Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.	

SOURCE: CDC Centers for Disease Control and Prevention National Center for Injury Prevention and Control