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

Appointment Date & Time: _____

Medicare Wellness Annual Visit Patient Checklist

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

GENERAL REIVEW:

1. How confident are you that you can control and manage your healthcare?	o Very confident o Somewhat confident o Not very confident
2. How often do you have trouble taking medicines the way that you have been told to take them?	o I always take them as prescribed. o I sometimes take them as prescribed. o I rarely take them as prescribed.
3. How would you rate your health in general?	o Excellent o Good o Fair o Poor
4. How much bodily pain have you had in general? If you checked Mild-Severe Pain, please rate it from 1 being the lowest and 10 being the worst.	o No Pain o Mild Pain o Moderate Pain o Severe Pain o _____
5. How many family members, including yourself, do you currently live with?	o _____
6. What is your current housing situation	o Own o Rent o Do not have housing. o Decline to answer.
7. Are you concerned about your current housing situation	o Yes o No o Decline to answer.
8. Has a lack of transportation kept you from medical appointments, or anything that is needed for daily living?	o Yes o No o Decline to answer
9. How often do you see or talk to people that you are close to or care about?	o Less than once a week o 1-4 times per week o 5 or more times per week

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

Appointment Date & Time: _____

10. In the past year, have you or any one in your household been unable to get any of the following due to financial strain?	o Food o Utilities o Clothing o Medications o Medical Appointments o Decline to answer.
11. Do you feel physically and emotionally safe where you currently live?	o Yes o No o Decline to answer.
12. Have you noticed a change in your vision over the past year?	o Yes o No
13. Have you noticed a change in your memory over the past year?	o Yes o No
14. Have you noticed a change in your hearing over the past year?	o Yes o No
15. Do you have a living will?	o Yes o No
16. Do you have a health care proxy or power of attorney?	o Yes o No
17. Please circle any of the following supplements that you take: Calcium Vitamin D Daily Multi-Vitamin Folic Acid B12 Iron Zinc Melatonin Probiotic Other (please indicate):_____	
18. Please list any specialist that participate in your care. _____ _____ _____ _____ _____	
19. Please list any medications and strength of medications that have changed in the last year. _____ _____ _____ _____	

VACCINE STATUS REVIEW:

20. Tetanus Booster (in the last 10 years)	o Yes o No o Unsure
21. Flu Shot (this year)	o Yes o No o Declined to receive it

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

Appointment Date & Time: _____

22. Pneumonia Vaccine (at any time)	o Yes o No o Unsure
23. Shingles Vaccine	o Yes o No o Unsure
24. Covid Vaccination	o 1 Dose o 2 Dose o 2 Dose + Booster o Declined to receive it
25. RSV	o Yes o No o Unsure

SUBSTANCE REVIEW:

26. During the past month how many drinks of wine, beer or alcohol or other alcoholic beverages have you consumed?	o More than 10 o 5-10 o Less than 5 o No alcohol at all
27. Do you use IV drugs, marijuana, cocaine, or other drugs?	o Yes o No o N/a
28. Have you recently or ever used tobacco?	o Yes o No
29. Have you ever used smokeless tobacco products?	o Yes o No

HEALTH SCREENINGS:

30. When was your last colonoscopy screening? If none, are you interested?	o _____ o Yes o Declines
31. Are you interested in having a Mammogram ordered? (Female Only)	o Yes o No o Declines or N/A
32. Are you interested in having a Bone Density Testing? (Female Only)	o Yes o No o Declines or N/A
33. If you have smoked for more than 20 years and are between ages 55-77, are you interested in lung cancer screening?	o Yes o No o Declines
34. Have you had a dilated eye exam in the past year? If yes, where at?	o Yes,_____ o No

Patient Name(Please print):_____ DOB:_____ Date:_____

Review of Systems(Please check the following symptoms that you have now).

General:

- Fever
- Unintentional Weight Gain
- Unintentional Weight Loss
- Chills
- Fatigue
- Other_____

Eyes:

- Dry Eyes
- Vision Changes
- Eye Irritation
- Other_____

Ear/Nose/Throat

- Ringing in Ears
- Difficulty Hearing
- Ear Pain
- Sore Throat
- Mouth Sores
- Teeth Problems
- Nosebleeds
- Snoring
- Other_____

Cardiovascular:

- Chest Pain
- Palpitations
- Swelling of Feet/Ankles
- Heart Murmur
- Shortness of Breath
- Other_____

Respiratory:

- Cough
- Wheezing
- Difficulty Breathing
- Sleep Apnea
- Other_____

Gastrointestinal:

- Abdominal Pain
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Loss of Appetite
- Black or Tarry stools
- Reflux
- Other_____

Genitourinary:

- Urinary Loss of Control
- Painful Urination
- Blood in Urine
- Frequent Urination
- Other_____

Women:

- Painful Menses
- Irregular Menstrual Cycle
- Vaginal Discharge
- Vaginal Itching
- Other_____

Musculoskeletal:

- Neck Pain
- Muscle Aches/Cramps
- Joint Pain
- Back Pain
- Swelling in Extremities
- Osteoporosis
- Other_____

Skin/ Breast:

- Itching
- Dry Skin
- Rashes
- Growth/ Lesions
- Unusual Moles
- Non-Healing areas
- Breast Changes
- Other_____

Neurologic:

- Weakness
- Numbness
- Seizures
- Dizziness
- Headaches/Migraines
- Tremor
- Restless Leg
- Paralysis
- Other_____

Psychiatric:

- Excessive Sadness
- Trouble Sleeping
- Anxiety
- Suicidal Thoughts
- Memory Loss
- Mood Swings
- Other_____

Endocrine:

- Intolerance to Cold/Heat
- Excessive Hair Loss/Growth
- Other_____

Blood/Lymphatic:

- Swollen Glands
- Easily Bruising
- Excessive Bleeding
- Anemia
- Other_____

Allergic/Immunologic:

- Sinus Pressure
- Frequent Sneezing
- Hives
- Runny Nose
- Other_____

Do you or have you smoke_____ If yes, how long?_____ Packs per day_____ # of years_____
Do you drink alcohol_____ Drinks per week_____ # of years_____
How many cups of caffeine do you have per day(coffee/tea/soda)_____
Do you participate in sports or exercise_____
If yes, what and how often_____

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