MEDICARE WELLNESS CHECKUP QUESTIONNAIRE

Name, date of birth, gender and today's date ____Date________

List any vaccines you had this year:____

List hospitalizations/ER visit dates Mo/Yr and location____

____

When was your last eye exam: _______________________Last dental exam: _________________________

List any new specialist doctors that you have seen this year:

____

____

1. What is your race? (**Check all that apply**)
   a. White
   b. Black or African American
   c. Asian
   d. Native Hawaiian or other Pacific Islander
   e. American Indian or Alaskan Native
   f. Hispanic or Latino origin or descent
   g. Other

2. During the **past four weeks**, how much bodily pain have you generally had?
   Please indicate if it is chronic or acute and where after the letter.
   h. No pain
   i. Very mild pain ____
   j. Mild pain ____
   k. Moderate pain____
   l. Severe pain ____

3. During the **past four weeks**, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself).
   a. Yes, as much as I wanted
   b. Yes, quite a bit
   c. Yes, some
   d. Yes, a little
   e. No, not at all

4. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?
   a. Very heavy
   b. Heavy
   c. Moderate
   d. Light
   e. Very light

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5. Can you get to places that are out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)
   a. Yes
   b. No

6. Can you go shopping for groceries or clothes without someone's help?
   a. Yes
   b. No

7. Can you prepare your own meals?
   a. Yes
   b. No

8. Can you do your housework without help?
   a. Yes
   b. No

9. 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?
   a. Yes
   b. No

10. Can you handle your own money without help?
    a. Yes
    b. No

11. During the **past four weeks**, how would you rate your health in general?
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor

12. Are you having problems with your memory or making calculations? Have close friends or family expressed concerns? Please describe any problems or comments from others:

    ____

    ____

    ____

13. Are you having difficulties driving your car?
    a. Yes, often
    b. Sometimes
    c. No
    d. Not applicable, I do not use a car

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14. Do you always fasten your seat belt when you are in a car?
    a. Yes, always
    b. Yes, usually
    c. Yes, sometimes
    d. No

15. Have you noticed a change in your hearing (circle all that apply):
    a. Yes
    b. No
    c. I wear hearing aids

16. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up	l	l	l	l	l
Sexual problems	l	l	l	l	l
Trouble eating well	l	l	l	l	l
Teeth or denture problems	l	l	l	l	l
Problems using the telephone	l	l	l	l	l
Tiredness or fatigue	l	l	l	l	l

17. Do you lose control of your bladder?
    a. Yes
    b. No
    c. Sometimes

18. Have you fallen two or more times in **the past year**?
    a. Yes
    b. No

19. Are you afraid of falling?
    a. Yes
    b. No

20. Do you use any aids or devices: Circle all that apply

    a. Cane
    b. Walker
    c. Wheelchair
    d. Crutches
    e. Special built up chair
    f. Devices for dressing
    g. None of the above

21. Do you exercise for about 20 minutes three or more days a week?
    a. Yes, most of the time.
    b. Yes, some of the time.
    c. No, I usually do not exercise this much.

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22. Are you a smoker?
    a. No
    b. Yes, and I might quit
    c. Yes, but I'm not ready to quit

23. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have? Answer all that apply
    a. 10 or more drinks per week
    b. 6-9 drinks per week
    c. 2-5 drinks per week
    d. 3 or more drinks in one sitting
    e. One drink or less per week
    f. No alcohol at all

24. Are there hazards in your house that might cause you harm or cause you to come to harm? For example, loose rugs, poor lighting, clutter, lack of grab bars where needed, lack of smoke detectors…
    a. Yes
    b. No
    c. Please circle any in the question or name hazards here: ________________________________
    ____

25. Do you keep track of your medications?
    a. Yes
    b. No

26. How often do you have trouble taking medicines the way you have been told to take them?
    a. I do not have to take medicine
    b. I always take them as prescribed
    c. Sometimes I take them as prescribed
    d. I seldom take them as prescribed

27. Do you have an advanced care directive? or a POLST? Or both
    a. Yes Advanced Care Directive
    b. Yes POLST
    c. No I don't have either
    d. I don't know what that is

28. How confident are you that you can control and manage most of your health problems?
    a. Very confident
    b. Somewhat confident
    c. Not very confident
    d. I do not have any health problems

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29. Please complete the following by circling your response (if you have not done so online before today's appointment).

PHQ-4				
Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

Thank you for completing your Medicare Wellness Checkup. Please give it to your doctor or nurse

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