MEDICARE WELLNESS CHECKUP

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

Your name: _____

_____

Today's date: _____

Your date of birth: _____

1. Over the last two weeks, how often have you been bothered by any of the following problems:

   A. Feeling down, depressed or hopeless?

   O Not at all.
   O Several Days
   O More than half the days
   O Nearly Every Day

   B. Little interest or pleasure doing things?

   O Not at all.
   O Several Days
   O More than half the days
   O Nearly Every Day

2. During the past four weeks, how much bodily pain have you generally had?

   O No pain.
   O Very mild pain.
   O Mild pain.
   O Moderate pain.
   O 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 talking care of yourself.)

   O Yes, as much as I wanted.
   O Yes, quite a bit.
   O Yes, some.
   O Yes, a little.
   O No, not at all.

4. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?

   O Very heavy.
   O Heavy.
   O Moderate.
   O Light.
   O Very light

5. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)

   O Yes. O No.

6. Can you go shopping for groceries or clothes without someone's help?

   O Yes. O No.

7. Can you prepare your own meals?

   O Yes. O No.

8. Can you do your housework without help?

   O Yes. O No.

9. Can you handle your own money without help?

   O Yes. O No.

10. 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?

    O Yes. O No.

11. During the past four weeks, how would you rate your health in general?

    O Excellent.
    O Very good.
    O Good.
    O Fair.
    O Poor.

continued ➤

12. How have things been going for you during the past four weeks?

O Very well; could hardly be better.
O Pretty well.
O Good and bad parts about equal.
O Pretty bad.
O Very bad; could hardly be worse.

13. Are you having difficulties driving your car?

O Yes, often.
O Sometimes.
O No.
O Not applicable, I do not use a car.

14. Do you always fasten your seat belt when you are in a car?

O Yes, usually.
O Yes, sometimes.
O No.

15. 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.	O	O	O	O	O
Sexual problems.	O	O	O	O	O
Trouble eating well.	O	O	O	O	O
Teeth or denture problems.	O	O	O	O	O
Problems using the telephone.	O	O	O	O	O
Tiredness or fatigue.	O	O	O	O	O

16. Have you fallen two or more times in the past year?

O Yes. O No.

17. Are you afraid of falling?

O Yes. O No.

18. Are you a smoker?

☐ No.
☐ Yes, and I might quit.
☐ Yes, but I'm not ready to quit.

19. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?

O 10 or more drinks per week.
O 6-9 drinks per week.
O 2-5 drinks per week.
O One drink or less per week.
O No alcohol at all.

20. Has anyone ever told you that you may have a drinking problem?

O Yes
O No

21. Do you exercise for about 20 minutes three or more days a week?

O Yes, most of the time.
O Yes, some of the time.
O No, I usually do not exercise this much.

22. Do you feel you need any information to help you with the following:

Hazards in your house that might hurt you?

O Yes. O No.

Keeping track of your medications?

O Yes. O No.

23. How often do you have trouble taking medicines the way you have been told to take them?

O I do not have to take medicine.
O I always take them as prescribed.
O Sometimes I take them as prescribed.
O I seldom take them as prescribed.

24. List specialists you are currently seeing.

Eye Doctor_____

Other Doctors_____

_____

_____

_____

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Family Practice Management