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. What is your age?

☐ 65-69. ☐ 70-79. ☐ 80 or older.

2. Are you a male or a female?

☐ Male. ☐ Female.

3. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

4. During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

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

☐ No pain.
☐ Very mild pain.
☐ Mild pain.
☐ Moderate pain.
☐ Severe pain.

6. 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.)

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

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

☐ Very heavy.
☐ Heavy.
☐ Moderate.
☐ Light.
☐ Very light.

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

☐ Yes. ☐ No.

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

☐ Yes. ☐ No.

10. Can you prepare your own meals?

☐ Yes. ☐ No.

11. Can you do your housework without help?

☐ Yes. ☐ No.

12. 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?

☐ Yes. ☐ No.

13. Can you handle your own money without help?

☐ Yes. ☐ No.

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

☐ Excellent.
☐ Very good.
☐ Good.
☐ Fair.
☐ Poor.

continued ➤

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

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

16. Are you having difficulties driving your car?

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

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

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

18. 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.	☐	☐	☐	☐	☐
Sexual problems.	☐	☐	☐	☐	☐
Trouble eating well.	☐	☐	☐	☐	☐
Teeth or denture problems.	☐	☐	☐	☐	☐
Problems using the telephone.	☐	☐	☐	☐	☐
Tiredness or fatigue.	☐	☐	☐	☐	☐

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

☐ Yes. ☐ No.

20. Are you afraid of falling?

☐ Yes. ☐ No.

21. Are you a smoker?

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

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

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

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

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

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

☐ Yes. ☐ No.

Keeping track of your medications?

☐ Yes. ☐ No.

25. 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.

26. 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.

27. What is your race? **(Check all that apply.)**

- ☐ White.
- ☐ Black or African American.
- ☐ Asian.
- ☐ Native Hawaiian or other Pacific Islander.
- ☐ American Indian or Alaskan Native.
- ☐ Hispanic or Latino origin or descent.
- ☐ Other.

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

Family Practice Management

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

MEDICARE ANNUAL WELLNESS EXAM HISTORY FORM—INITIAL revised 10/2/12

First Name_____ Last Name_____ Date of Birth _____ Today's date _____

What is the Medicare Wellness Exam? (MWE) is a new service provided by Medicare at no cost to its beneficiaries. Please note that the MWE was designed to provide an assessment of your personal preventive health needs and is designed to include measures of weight and height but it is *not a full physical as you may have been used to in the past. However if you need a pap smear, prostate exam, or follow-up for chronic medical problems please schedule a separate visit for that purpose.*

Please follow the instruction given on this form and bring the completed form and all requested information when you come for your Medicare Wellness Exam (MWE)

1. ATTACH A LIST OF ALL PRESCRIPTION MEDICINES YOU TAKE INCLUDING THE STRENGTH AND FREQUENCY WITH WHICH YOU TAKE THEM.
2. ATTACH A LIST OF YOUR OTHER HEALTH CARE PROVIDERS INCLUDING SPECIALISTS YOU SEE, LOCAL AND MAIL ORDER PHARMACIES YOU USE.
3. COMPLETE THE **PHQ9 SCREENING QUESTIONNAIRE** AND THE **"MEDICARE WELLNESS CHECKUP"** HEALTH RISK ASSESSMENT WHICH YOU SHOULD HAVE RECEIVED WITH THIS FORM.
4. DRAW THE FACE OF A CLOCK IN THE SPACE PROVIDED HERE, AND PUT THE NUMBERS IN THEIR CORRECT POSITIONS. THEN DRAW IN THE HANDS OF THE CLOCK TO SHOW 20 MINUTES AFTER NINE (9:20).

5. ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL HISTORY, EVEN IF YOU FEEL WE ALREADY HAVE THE INFORMATION ON FILE.

MEDICAL HISTORY Indicate if you have or ever had: high blood pressure ☐ diabetes ☐ high cholesterol ☐ arthritis ☐ asthma ☐ emphysema ☐ angina ☐ blocked arteries in heart ☐ heart attack ☐ , when?_____ stroke ☐ , when? _____ atrial fibrillation ☐ cancer ☐ , what kind(s)? _____ underactive thyroid ☐ other major illness _____

SURGERIES Please indicate if you have had hysterectomy ☐ both ovaries out ☐ appendix out ☐ tonsils out ☐ gallbladder out ☐ open heart for bypass ☐ list any other major operations _____

ALLERGIES: Please indicate if you have been allergic to or had a bad reaction to the following: no allergies ☐ penicillin ☐ sulfa ☐ codeine ☐ aspirin ☐ iodine ☐ latex (rubber) ☐ flu shots ☐ other allergies _____

TOBACCO USE: Please indicate if you never smoked ☐ smoke ☐ _____ Packs a day have quit smoking ☐ when? _____

ALCOHOL USE: non-drinker ☐ on rare occasion ☐ socially ☐ 2 drinks or less per day ☐ other amount _____

FAMILY HISTORY: Please check if your mother, father, sisters, brothers or children have had: heart attack ☐ diabetes ☐ asthma ☐ high blood pressure ☐ high cholesterol ☐ thyroid disease ☐ hardening of the arteries ☐ severe arthritis ☐ stroke ☐ cancer ☐ (what kinds?) _____ other major illness_____

Please list any active symptoms you have that concern you:_____

_____

If you have symptoms which do not require urgent attention we can schedule you to return to address these in the near future.

VACCINATIONS & HEALTH SCREENINGS

What year was your last: pneumonia shot_____ flu shot_____ shingles vaccine_____ tetanus shot_____ EKG_____

What year was your last Colonoscopy? _____ Have you ever had colon polyps? yes ☐ no ☐

LADIES ONLY:

Date of last mammogram _____ Date of last pap smear _____ Date of last scan for osteoporosis _____