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 of a female?

☐ Male ☐ Female

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

☐ No pain
☐ Very mild pain
☐ Mild pain
☐ Moderate pain
☐ Sever pain

4. 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

5. 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

6. 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

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

☐ Yes ☐ No

8. Can you prepare your own meals?

☐ Yes ☐ No

9. Can you do your housework without help?

☐ Yes ☐ 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?

☐ Yes ☐ No

11. Can you handle your own money without help?

☐ Yes ☐ No

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

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

13. 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

14. Are you having difficulties driving your car?

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

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

☐ Yes, usually
☐ Yes, sometimes
☐ No

continued ➤

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

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

☐ Yes ☐ No

18. Are you afraid of falling?

☐ Yes ☐ No

19. Are you a smoker?

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

20. 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 or more drinks per week
☐ One drink or less per week
☐ No alcohol at all

21. 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

22. 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

23. 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

24. 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

25. 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

(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	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 or 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 are 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

FOR OFFICE CODING 0 + ____ + ____ + ____

= TOTAL SCORE: ____

If you have checked off any problems, 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 at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

26. In the **past 7 days**, how many servings of fruits and vegetables did you typically eat each day? (1 serving=1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup=size of a baseball.) ___servings per day

27. In the **past 7 days**, how many servings of high fiber or whole grain foods did you typically eat each day? (1 serving=1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.) ___servings per day

28. In the **past 7 days**, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream cheese, or mayonnaise.) ____servings per day

29. In the **past 7 days**, how many sugar-sweetened (not diet) beverages did you typically consume each day? _____

30. In the **past 2 weeks**, how often have you felt nervous, anxious, or on edge?
☐Almost all of the time ☐Most of the time
☐Some of the time ☐Almost Never

31. In the **past 2 weeks**, how often were you not able to stop worrying or control your worrying?
☐Almost all of the time ☐Most of the time
☐Some of the time ☐Almost Never

32. How often is stress a problem for you in handling such things as: Your health, finances, family or social relationships and/or work?
☐Never or rarely ☐Sometimes
☐Often ☐Always

33. How often do you get the social and emotional support you need?
☐Always ☐Usually
☐Sometimes ☐Rarely

34. Each night, how many hours of sleep do you usually get?
___ Hours

35. Do you snore or has anyone told you that you snore?
☐Yes ☐No

36. In the **past 7 days**, how often have you felt sleepy during the daytime?
☐Always ☐Usually
☐Sometimes ☐Rarely

Biometric Measures-Self Reported
(Please fill in below questions if the following items have not been recorded in by the office in the last year)

Blood Pressure

37. If your blood pressure was checked within the **past year**, what was it when it was last checked?
☐Low or normal (at or below 120/80)
☐Borderline high (120/80 to 139/89)
☐High (140/90 or higher)
☐Don't know/not sure

Cholesterol

38. If your cholesterol was checked within the **past year**, what was your total cholesterol when it was last checked?
☐Desirable (below 200)
☐Borderline high (200–239)
☐High (240 or higher)
☐Don't know/not sure

Blood Glucose

39. If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?
☐ Desirable (below 100)
☐ Borderline high (100-125)
☐ High (126 or higher)
☐ Don't know/not sure

40. If diabetic, and if you have had your hemoglobin A1c level checked in the **past year**, what was it the last time you had it checked?
☐ Desirable (6 or lower)
☐ Borderline high (7)
☐ High (8 or higher)
☐ Don't know/not sure

Overweight/Obesity

41. What is your height without shoes? (for example, 5 feet and 6 inches = 5'6")
Feet _____ Inches _____

42. What is your weight?
Weight in pounds _____

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