Name: _____ Date: _____ Date of Birth: _____

# A Checklist for Your Medicare Wellness Annual Visit

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

1. During the past 4 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

2. During the past 4 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

3. During the past 4 weeks, how much bodily pain have you generally had?
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain

4. During the past 4 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 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
   - ☐ Very heavy
   - ☐ Heavy
   - ☐ Moderate
   - ☐ Light
   - ☐ Very light

| | Yes | No |
|---|---|---|
| 6. Can you get to places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car? | | |
| 7. Can you shop for groceries or clothes without help? | | |
| 8. Can you prepare your own meals? | | |
| 9. Can you do your own housework without help? | | |
| 10. Can you handle your own money without help? | | |
| 11. Do you need help eating, bathing, dressing, or getting around your home? | | |

12. During the past 4 weeks, how would you rate your health in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

13. How have things being going for you during the past 4 weeks?
   - ☐ Very well, could hardly be better
   - ☐ Pretty good
   - ☐ 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

| 16. How often during the past 4 weeks have you been bothered by any of the following problems? | Never | Seldom | Sometimes | Often | Always |
|---|---|---|---|---|---|
| Fall or dizzy when standing up | | | | | |
| Sexual problems | | | | | |
| Trouble eating well | | | | | |
| Teeth or dentures | | | | | |
| Problems using the telephone | | | | | |
| Tired or fatigued | | | | | |

17. Have you fallen in the past year?
- ☐ Yes
- ☐ No

If yes, how many times? _____

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 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have?
- ☐ 10 or more per week
- ☐ 6-9 per week
- ☐ 2-5 per week
- ☐ 1 drink or less per week
- ☐ No alcohol at all

21. Do you exercise for about 20 minutes 3 or more days a week?
- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ No, I usually do not exercise that 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 issues

How old are you?
____ 65 - 69 ____70 - 75 ____ 80 or older

Are you male or female? ____ Male ____ Female

What is your race? (Check one or more than one)
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaskan Native
- ☐ Hispanic or Latino origin or descent
- ☐ Other

_____
Patient Signature

_____
Today's Date