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Name:_____Date:_____Date of Birth:_____

A CHECKLIST FOR YOUR MEDICARE ANNUAL WELLNESS 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 2 weeks, how often have you been bothered by any of the following problems? Use a "✓" to indicate your answer:	Not at all	Several Days	More than half the days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things such as reading the newspaper or watching T.V.	0	1	2	3
Moving or speaking 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
Thoughts that you would be better off dead or hurt yourself in some way	0	1	2	3

For office staff only: total PHQ-9 score: [ ] 1-4 points [ ] **5-9 points** [ ] **> 9**

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. How have things been 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**

4. 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 never take them as prescribed**

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

6. Do you have difficulty hearing?
☐ **Yes** ☐ No ☐ **I wear hearing aids**

7. Do you wear glasses/contact lenses?
☐ **Yes** ☐ No ☐ **I should but I don't**

Please answer the following:	Yes	**No**
8. Can you get places beyond walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?	☐	☐
9. Can you shop for groceries or clothes without help?	☐	☐
10. Can you prepare your own meals?	☐	☐
11. Can you do your own housework without any help?	☐	☐
12. Can you handle your own money without help?	☐	☐
13. Do you need help eating, bathing, dressing, or getting around in your home?	☐	☐

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

15. What helps relieve pain? ☐ Not Applicable
- ☐ **Prescription Pain Meds**
- ☐ Over the counter
- ☐ Non-Medication therapies (like Ice, Heat, etc.)

How often? _____

16. Answer the following about your home environment	Yes	No	N/A
Rooms and hallways are dim (not well lit)	☐	☐	☐
You have a Pool or spa	☐	☐	☐
You have rugs in room(s) or hallway(s)	☐	☐	☐
You have stairs with no hand rails	☐	☐	☐
You do not have any grab bars in your shower or bath	☐	☐	☐
You have unsecured firearms in your home	☐	☐	☐
You have working carbon monoxide detectors	☐	☐	☐

17. During the <u>past 4 weeks</u> what was the hardest physical activity you could do for at least 2 minutes?

☐ Very heavy ☐ **Light**
☐ Heavy ☐ **Very light**
☐ Moderate

18. Are you a smoker?

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

19. Do you always wear your seatbelt when you are in a car?

☐ Yes, usually ☐ **Yes, sometimes** ☐ **No**

20. 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 this much**

21. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have per week?

☐ **10 or more** ☐ 1 drink or less per week
☐ 6-9 per week ☐ No alcohol at all
☐ 2-5 per week

22. "Stay Independent" Fall Risk Assessment

Check "Yes" or "No" for each statement	yes	no
I have fallen in the past year	☐	☐
I use or have been advised to use a cane or walker to get around safely.	☐	☐
Sometimes I feel unsteady when I am walking.	☐	☐
I steady myself by holding onto furniture when walking at home.	☐	☐
I am worried about falling	☐	☐
I need to push with my hands to stand up from a chair.	☐	☐
I have some trouble stepping up onto a curb	☐	☐
I often have to rush to the toilet.	☐	☐
I have lost some feeling in my feet	☐	☐
I take medicine that sometimes makes me feel light-headed or more tired than usual.	☐	☐
I take medicine to help me sleep or improve my mood.	☐	☐
I often feel sad or depressed	☐	☐

For Office staff: (add 1 point for every "yes" answer)
[ ] 1-3 total points [ ] **4 or more points**

23. Please answer the following:

Check each Box and add date/result, if known	Yes/Date	Result	No or N/A	Unknown
Did you get your flu shot?		N/A	☐	☐
Have you ever received a pneumonia vaccine?		N/A	☐	☐
Have you had your mammogram?		☐Normal ☐Abnormal	☐	☐
Have you had a test for bowel / colon cancer?		☐Normal ☐Abnormal	☐	☐