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MEDICARE-REQUIRED QUESTIONNAIRE FOR ANNUAL PREVENTIVE EXAM

Name: ______________________________ Date of Birth: ____________ Date: ____________

- Please put a check mark next to any of the following symptoms you have had every day for two weeks in a row:

______ Depressed mood

______ Trouble sleeping

______ Decreased interest in activities or decreased pleasure from activities

______ Feeling of guilt or worthlessness

______ Decreased energy

______ Difficulty falling asleep

______ Difficulty concentrating

______ Decreased appetite or weigh loss

______ Feeling your movements have been slowed down or sped up

______ Suicidal thoughts

(For MD use: Score = ______ Interpretation: ________________________ Prov:____________)

- Do you have an Advanced Directive indicating your wishes in the event you are unable to communicate with anyone due to medical problems? ______ Yes ______No

- We can provide you with a kit to complete your Advanced Directives if you need one. Do you need a kit? ______Yes _____No

- Have you fallen in the last three months? ______Yes ______No

- Is there anything in your home that you consider unsafe? ______Yes ______No
  -If yes, we may refer you to a home health agency that can do a home safety evaluation which is covered by Medicare.

- Do you have trouble hearing that is interfering with your activities or preventing you from doing things that you want to do? ______Yes ______No

Physical activity:

- In the past 7 days, how many days did you exercise? _______days
- On days when you exercised, for how long did you exercise? ______ Minutes
- How intense was your typical exercise?
  - ☐ Light (Like stretching or slow walking)
  - ☐ Moderate? (like brisk walking)
  - ☐ Heavy (Like jogging or swimming)
  - ☐ Very heavy (like fast running or stair climbing)
  - ☐ I am currently not exercising

Tobacco use

- In the last 30 days, have you smoked tobacco? ____Yes ____No
  -If yes, would you be interested in quitting tobacco use within next month __Yes ___No

Alcohol use

- In the past 7 days, how many days did you drink alcohol? _____Days
- What was the most drinks per day? _____Drinks
- Do you drive after drinking or ride with a driver who has been drinking? ___Yes ___No

Nutrition

- 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 = the size of a baseball.)

  ________servings per day

- In the past 7 days, how many serving 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, 1 cup of cooked cereal such as oatmeal. Or ½ cup of cooked brown rice or wheat pasta)

  ________ servings per day

- 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, baked potatoes, chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream cheese or mayonnaise.)

  ________ servings per day

- In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day? ____ beverages. Type of beverage: ______________________.

Seat belt use

- Do you always fasten your seatbelt when you are in a car? _____Yes _____No

Pain

- In the past 7 days, how much pain have you felt? ___None ___Some ___A lot

Activities of daily living

- In the past 7 days, did you need help from others to perform everyday activities such as getting dressed, grooming, walking, or using the toilet? _______Yes _______No

Instrumental activates of daily living

In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications? ____Yes ____No

Sleep

- Each night how many hours of sleep do you usually get? _____Hours
- Do you snore or has anyone told you that you snore? _____ Yes _______ No
- In the past 7 days, how often have you felt sleepy during the daytime?

  - ☐ Always
  - ☐ Usually
  - ☐ Sometimes
  - ☐ Rarely
  - ☐ Never