

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.

1. What is your age?

- 65-69. 70-79. 80 or older.

2. Are you a female or a male?

- 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.

Your name: _____

Today's date: _____

Your date of birth: _____

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, 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble eating well.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth or denture problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems using the telephone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness or fatigue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

Let's talk urinary incontinence: (please read below and then answer as directed)

Do you have a big problem? Meaning:

- *You leak urine on a daily basis
- *You are currently on a prescription for urinary leakage
- *You have had surgery for the problem

Do you have a small problem? Meaning:

- *You leak urine occasionally, such as when you laugh or cough
- *You are treating the problem with bladder exercises

Do you have no problem at all? Meaning:

- *You currently experience NONE of the symptoms above- but remember to talk with your doctor about any concerns you might have if this issue were to arise in the future.

Now that you know the differences, what's your assessment?? Please answer below:

I have a _____ (big/small/no) problem with urinary incontinence.

Let's talk falls: (please read below and then answer as directed)

Do you have a big problem? Meaning:

- *You have had a fall
- *You currently use a cane or walker
- *You have a vision or hearing problem
- *You have high blood pressure

Do you have a small problem? Meaning:

- *You have trouble with balance

Do you have no problem at all? Meaning:

- *You currently may not have a problem with falls, but remember to talk with your doctor about any concerns you might have if this issue were to arise in the future.

Now that you know the differences, what's your assessment?? Please answer below:

I have a _____ (big/small/no) problem with falls.



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