Name:____________________Date____________DOB________________

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 four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?

   a. Not at all
   b. Slightly
   c. Moderately
   d. Quite a bit
   e. Extremely

2. During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?

   a. Not at all
   b. Slightly
   c. Moderately
   d. Quite a bit
   e. Extremely

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

   a. No Pain
   b. Very mild pain
   c. Mild pain
   d. Moderate pain
   e. Severe pain

4. During the last 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?

   a. Yes, as much as I wanted
   b. Yes, quite a bit
   c. Yes, some
   d. Yes, a little
   e. No, not at all

5. During the past 4 weeks what was the hardest physical activity you could do for at least 2 minutes?

   a. Very heavy
   b. Heavy
   c. Moderate
   d. Light
   e. Very light

6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?

   a. Yes
   b. No

7. Can you shop for groceries or clothes without help?
    a. Yes
    b. No

8. Can you prepare your own meals?
    a. Yes
    b. No

9. Can you do your own housework without help?
    a. Yes
    b. No

10. Can you handle your own money without help?
    a. Yes
    b. No

11. Are you able to eat, bathe and get around your house without assistance?
    a. Yes
    b. No

12. During the past 4 weeks, how would you rate your health in general?
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor

13. Have you fallen 2 or more times in the past year?
    a. No
    b. Yes

14. How have things been going for you during the past 4 weeks?
    a. Very well- could hardly be better
    b. Pretty good
    c. Good and bad parts about equal
    d. Pretty bad
    e. Very bad- could hardly be worse

15. Are you having difficulties driving your car?
    a. No
    b. Sometimes
    c. Yes, often
    d. Not applicable, I do not use a car

16. Do you always fasten your seat belt when you are in a car?
    a. Yes
    b. Sometimes
    c. No
    d. Not applicable, I do not use a car

17. 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	☐	☐	☐	☐	☐

18. Are you afraid of falling?
    a. No
    b. Yes

19. Are you a smoker?
    a. No
    b. Yes

20. Have you ever smoked?
    a. No
    b. Yes

21. If so, how much do/did you smoke?
    ________ packs per day
    ________ years

22. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have?
    a. No alcohol at all
    b. 1 drink or less per week
    c. 2-5 per week
    d. 6-9 per week
    e. 10 or more per week

23. Have you ever felt you need to cut down on your drinking?
    a. No
    b. Yes

24. Have people annoyed you by criticizing your drinking?
    a. No
    b. Yes

25. Have you ever felt guilty about your drinking?
    a. No
    b. Yes

26. Have you ever felt you needed a drink first thing in the morning to steady your nerves or get rid of a hangover?
    a. No
    b. Yes

27. Do you exercise for about 20 minutes 3 or more days a week?
    a. Yes, most of the time
    b. Yes, some of the time
    c. No I usually do not exercise this much

28. Have you been given any information to help you with the following:
    a. Hazards in your house that might hurt you?
        i. Yes
        ii. No

    b. Keeping track of your medications?
        i. Yes
        ii. No

29. How often do you have trouble taking medicines the way you have been told to take them?
    a. I do not have to take medicine
    b. I always take them as prescribed
    c. Sometimes I take them as prescribed
    d. I seldom take them as prescribed

30. How confident are you that you can control and manage most of your health problems?
    a. Very confident
    b. Somewhat confident
    c. Not very confident
    d. I do not have any health problem

31. How much of a problem, if any, is bladder control for you?
    a. Big problem
    b. Small problem
    c. Not a problem at all