

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.

Your name: _____
Today's date: _____
Your date of birth: _____

1. What is your age?

- 65-69 70-79 80 or older

2. Are you a male or a female?

- Male Female

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

- No pain
 Very mild pain
 Mild pain
 Moderate pain
 Severe pain

4. 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

5. 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

6. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)

- Yes No

7. Can you go shopping for groceries or clothes without someone's help?

- Yes No

8. Can you prepare your own meals?

- Yes No

9. Can you do your housework without help?

- Yes No

10. 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

11. Can you handle your own money without help?

- Yes No

12. During the **past four weeks**, how would you rate your health in general?

- Excellent
 Very good
 Good
 Fair
 Poor

13. 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

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

continued >

16. 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					
Sexual problems					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					
Tiredness or fatigue					

17. Have you fallen two or more times in **the past year**?

- Yes No

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 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 or more drinks per week
 One drink or less per week
 No alcohol at all

21. 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

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 problems

25. 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

(PHQ-9)				
	Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)			
	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 or 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 are 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
FOR OFFICE CODING <u> 0 </u> + <u> </u> + <u> </u> + <u> </u> = TOTAL SCORE: <u> </u>				
If you have checked off <u>any</u> problems, how difficult have these 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	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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26. 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=size of a baseball.) ___servings per day
27. In the **past 7 days**, how many servings 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, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.) ___servings per day
28. 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, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream cheese, or mayonnaise.) ___servings per day
29. In the **past 7 days**, how many sugar-sweetened (not diet) beverages did you typically consume each day? _____
30. In the **past 2 weeks**, how often have you felt nervous, anxious, or on edge?
Almost all of the time Most of the time
Some of the time Almost Never
31. In the **past 2 weeks**, how often were you not able to stop worrying or control your worrying?
Almost all of the time Most of the time
Some of the time Almost Never
32. How often is stress a problem for you in handling such things as: Your health, finances, family or social relationships and/or work?
Never or rarely Sometimes
Often Always
33. How often do you get the social and emotional support you need?
Always Usually
Sometimes Rarely
34. Each night, how many hours of sleep do you usually get?
 ___ Hours
35. Do you snore or has anyone told you that you snore?
Yes No
36. In the **past 7 days**, how often have you felt sleepy during the daytime?
Always Usually
Sometimes Rarely

Biometric Measures-Self Reported

(Please fill in below questions if the following items have not been recorded in by the office in the last year)

Blood Pressure

37. If your blood pressure was checked within the **past year**, what was it when it was last checked?
Low or normal (at or below 120/80)
Borderline high (120/80 to 139/89)
High (140/90 or higher)
Don't know/not sure

Cholesterol

38. If your cholesterol was checked within the **past year**, what was your total cholesterol when it was last checked?
Desirable (below 200)
Borderline high (200-239)
High (240 or higher)
Don't know/not sure

Blood Glucose

39. If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?
Desirable (below 100)
Borderline high (100-125)
High (126 or higher)
Don't know/not sure
40. If diabetic, and if you have had your hemoglobin A1c level checked in the **past year**, what was it the last time you had it checked?
Desirable (6 or lower)
Borderline high (7)
High (8 or higher)
Don't know/not sure

Overweight/Obesity

41. What is your height without shoes? (for example, 5 feet and 6 inches = 5'6")
 Feet _____ Inches _____
42. What is your weight?
 Weight in pounds _____

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse