Northwest PRIMARY CARE

Medicare Wellness Checkup

Legal Name: _____ DOB: _____ Date: _____

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health care possible.

1. What is your age?

☐ 65-69 ☐ 70-79 ☐ 80 or older

2. Are you male or female?

☐ 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 your 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

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 or 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

MEDICARE WELLNESS CHECKUP

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

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.