

## **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?

- 18-64     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 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

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: \_\_\_\_\_

Your date of birth: \_\_\_\_\_

Today's date: \_\_\_\_\_

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

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