

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"/>	<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.