

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 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 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.

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.