Name: **Date of Birth:** **Today's Date:**

Thank you very much for completing your Medicare Wellness Questionnaire. Please bring the completed form to your appointment.

MEDICARE WELLINESS QUESTIONNAIRE

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

1. During the **past four weeks**, how would you rate your general health?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Decent
   - ☐ Fair
   - ☐ Poor

2. 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

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 pains have you generally had?
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Moderate pain
   - ☐ Severe pain

6. During the **past four weeks** have you been bothered by any of the following problems?

	YES	NO
Problems using the telephone		
Tiredness or fatigue		
Fever		
Unintentional weight loss		
Chest pain		
Dizziness		
Falling or dizzy when standing up		
Palpitations		
Difficulty breathing		
Cough		
Trouble eating well		
Teeth or denture problems		
Nausea or vomiting		
Abdominal pain		
Change in bowel movements		
Blood in the stool		
Pain on urination		
Sexual problems		
Women: Trouble controlling urine		
Women: Irregular vaginal bleeding		
Men: Excessive nighttime urination		
Unusual headache		
Numbness		
Memory Loss		

7. Have your fallen two or more times in **the past year**?
   - ☐ Yes ☐ No

8. Are you afraid of falling?
   - ☐ Yes ☐ No

9. 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

10. Are you having difficulties driving your car?
    ☐ Yes ☐ No

11. Do you always fasten your seat belt when you are in a car?
    ☐ Yes ☐ No

12. Can you go shopping for groceries or clothes without someone's help?
    ☐ Yes ☐ No

13. 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

14. Can you prepare your own meals?
    ☐ Yes ☐ No

15. Can you do your housework without help?
    ☐ Yes ☐ No

16. Can you handle your own money without help?
    ☐ Yes ☐ No

17. 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

18. 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

19. 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

20. How confident are you that you can control and manage most of your health problems?

    ☐ Very confident
    ☐ Somewhat confident
    ☐ Not very confident

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 her 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 thought about your wishes for health care at the end of your life? If yes, please ask for a **MOLST** form at your visit.
    ☐ Yes ☐ No

25. Do you have a Health Care Proxy? If yes, please be sure to bring it with you to your visit.
    ☐ Yes ☐ No

26. List any other Physicians you have seen in **the last year**.

_____

_____

_____

_____

_____