Name:	Date:	Date of Birth:

A Check list for Your Medicare Wellness Annual Visit

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

1. During the past 4 weeks, how much have you been bothered by emotionial problems such as feeling anxious, depressed, irritable or sad?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

2.During the past 4 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

3. During the past 4 weeks, how much bodily pain have you had?

- ☐ No Pain
- ☐ Very Mild Pain
- ☐ Mild Pain
- ☐ Moderate Pain
- ☐ Severe Pain

4. During the past 4 weeks, was someone available to help you if you needed and wanted help?

- ☐ Yes,as much as I wanted
- ☐ Yes, quite a bit
- ☐ Yes, some
- ☐ Yes, a little
- ☐ No, not al all

5. During the past 4 weeks, the hardest physical activity you could do for a least 2 minutes was?

- ☐ Very heavy
- ☐ Heavy
- ☐ Moderate
- ☐ Light
- ☐ Very Light

	Yes	NO
6. Can you travel alone by bus, taxi or drive your own car?		
7.Can you shop for groceries or clothing without help?		
8. Can you prepare your own meals?		
9.Can you do your own housework without help?		
10.Can you manage your own money without help?		
11.Do you need help eating, bathing,dressing or getting around your home?		

12.During the past 4 weeks, how would you rate your health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

13. Do you have a living will?

- ☐ Yes
- ☐ No

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14.Are you having difficulties driving your car?

- ☐ Yes, Often
- ☐ Sometimes
- ☐ No
- ☐ Not applicatble, I do not use a car

15.Do you always fasten your seatbelt when you are in a car?

- ☐ Yes, Usually
- ☐ Yes, Sometimes
- ☐ No, not al all

16. How often during the <u>past 4 weeks</u> have you been <u>bothered</u> by any of the following problems?

	Never	Seldom	Often	Always
Fall or dizzy when standing up				
Sexual problems				
Difficulty eating well				
Teeth or dentures				
Problems using the telephone				
Tired or fatigued				

17.Have you fallen 2 or more times in the past year?

☐ YES ☐ NO

18. Do you think you are at a high risk of falling?

☐ YES ☐ NO

19. Are you a smoker?

- ☐ No
- ☐ Yes, and I might quit
- ☐ Yes, but I'm not ready to quit

20.During the <u>past 4 weeks,</u> how many drinks of wine, beer or other alcoholic beverages did you have?

- ☐ 10 or more per week
- ☐ 6-9 per week
- ☐ 2-5 per week
- ☐ 1 drink or less per week
- ☐ No alcohol at all

21. Do you exercise at least 20 minutes, 3 or more days a week?

- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ No, I usually do not exercise this much

22. 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

23. 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

24. 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

Name:	Date:	Date of Birth:

What you should bring to you Annual Wellness Visit:

Names of all your Doctors:

Name:	Specialty

List all you medications:

Name of medication:	Dose (if you remember)