Medicare Wellness Questionnaire

Date of Visit:_____

Name: _____

DOB: _____ **Age:** _____ **Gender:** M / F

Address: _____

_____

Primary Phone: (_____)_____-_____

Secondary Phone: (_____)_____-_____

Insurance: _____

During the past four weeks...

How would you rate your health in general?
□ Excellent □ Very good □ Good
□ Fair □ Poor

How have things been going for you?
□ Very well; could hardly be better.
□ Pretty well.
□ Good and bad parts about equal.
□ Pretty bad.
□ Very bad; could hardly be worse.

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.

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.

How much bodily pain have you generally had?
□ No pain □ Very mild pain □ Mild pain.
□ Moderate pain □ Severe pain

Was someone available to help you if you needed and wanted help? (*For example, if you got sick and had to stay in bed; needed someone to talk to; needed help taking care of yourself.*)
□ Yes, as much as I wanted.
□ Yes, quite a bit.
□ Yes, some
□ Yes, a little
□ No, not at all.

What was the hardest physical activity you could do for at least two minutes?
□ Very heavy
□ Heavy.
□ Moderate.
□ Light.
□ Very light.

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

Can you go shopping for groceries or clothes without help?
□ Yes. □ No

Can you prepare your own meals?
□ Yes. □ No

Can you do your housework without help?
□ Yes. □ No

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

Can you handle your own money without help?
□ Yes □ No

Do you have difficulties driving your car?
□ Yes, often. □ Yes, sometimes. □ No
□ Not applicable, I do not drive.

Do you fasten your seat belt when you are in a car?
□ Yes, always □ Yes, sometimes □ No

Have you fallen <u>two or more times</u> in the past year?
□ Yes □ No

Are you afraid of falling?
□ Yes □ No

Have you been given any information to help you with the following:
Hazards in your house that might hurt you?
□Yes □ No, but I would like this
□ No, I am not interested in this
Keeping track of your medications?
□Yes □ No, but I would like this
□ No, I am not interested in this

How often do you have trouble taking medicines the way you have been told to take them?
□ I do not take any medicine.
□ I sometimes miss a dose of my medicine or take extra.
□ I often get confused with my medications.
□ I always take them as prescribed.

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.

How often during the past four weeks have you been bothered by any of the following problems?

Problem	Never	Seldom	Some-times	Often
Falling or dizzy when standing up				
Problems using the telephone				
Sexual problems				
Teeth or denture problems				
Tiredness or fatigue				
Trouble eating well				
Urine Leakage				

Screening Tests	Date Done	Declined
Bone Density		
Colonoscopy		
Endoscopy		
Eye Exam		
Labs/Blood Work		
Mammogram		
Sleep Study		
Stress Test		

Immunization	Date Given	Declined
Flu		
Pneumovax (pneumonia)		
Prevnar 13 (pneumonia)		
Tdap/Td (tetanus)		
Shingrix (shingles)		

***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.
- □ 1 drink or less per week.
- □ No alcohol at all.

Any current tobacco/nicotine use?

□ No. □ Yes, and I might quit
□ Yes, but I'm not ready to quit

If yes, what type of tobacco/nicotine?

□ cigarettes □ cigars
□ vape/e-cigarette □ chew/dip/snuff

Any current marijuana use?

□ No. □ Yes

Any changes in family medical history (siblings, children, grandchildren)?

□ No □ Yes (explain) _____

On average, how many days per week do you exercise for at least 20 minutes continuously?

□ I do not exercise this much
□ 1-2 □ 3-4 □ 5 or more

Do you have Advanced Directives (such as a living will and/or healthcare surrogate?

□ No □ Yes

Please rate your pain (circle your *CURRENT* pain level)

0 1 2 3 4 5 6 7 8 9 10
none mild moderate distressing severe unbearable

REVIEW OF SYSTEMS: (check *CURRENT* symptoms)

CONSTITUTIONAL:
□ Fever □ Weight loss/gain
EYES:
□ Double vision □ Blurred vision
EARS/NOSE/THROAT:
□ Ear Pain □ Decreased Hearing
□ Runny Nose □ Sore Throat
CARDIOVASCULAR:
□ Chest Pain □ Heart palpitations
RESPIRATORY:
□ Cough □ Wheezing
□ Shortness of breath
GASTROINTESTINAL:
□ Nausea □ Abdominal Pain
□ Constipation □ Diarrhea
□ Blood in stools
GENITOURINARY:
□ Frequent urination □ Painful urination
□ Blood in urine □ Vaginal bleeding
SKIN:
□ Rash □ Changing mole(s)
MUSCULOSKELETAL:
□ Pain located _____
□ Muscle weakness
NEUROLOGICAL:
□ Headache □ Lightheaded or dizzy
□ Numbness/tingling □ Recent fall(s)
□ Memory loss
PSYCHIATRIC:
□ Depression □ Anxiety
□ Suicidal thoughts
ENDOCRINE/HEMATOLOGIC:
□ Excessive thirst □ Bruises easily
□ Enlarged lymph nodes

_____ _____
Patient Signature **Date**

Depression Screening (PHQ-9)

Name: _____ **Date**: _____

DOB: _____ **Age**: _____ **Gender**: M / F

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**NOT AT ALL**	**SEVERAL DAYS**	**MORE THAN HALF THE DAYS**	**NEARLY EVERY DAY**
Little interest of pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

___Not difficult at all ___ Somewhat difficult ___ Very difficult ___ Extremely difficult

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Row Totals: _____ + _____ + _____ + _____

Total Score: _____

Total Score	Depression Severity
1-4	Minimal
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe