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REVIEW OF SYSTEMS

Fever______________No Yes
Chills______________No Yes
Malaise_____________No Yes
Fatigue_____________No Yes
Weight loss_________No Yes
Weight gain_________No Yes
↓ Appetite __________No Yes
↑ Appetite __________No Yes
Insomnia __________No Yes
Fluid retention______No Yes
Cold intolerance_____No Yes
Sweats_____________No Yes

Blurred vision_______No Yes
Cataracts___________No Yes
Eyelid itching_______No Yes
Floaters____________No Yes
Double vision_______No Yes

Nasal congestion____No Yes
Runny nose_________No Yes
Nasal itching________No Yes
Nose bleeds________No Yes
Postnasal drip______No Yes
Sore throat_________No Yes
Ear ringing_________No Yes
Hearing loss________No Yes
Ear pain____________No Yes
Clogged ears_______No Yes
Ear discharge_______No Yes

Cough______________No Yes
Wheezing___________No Yes
Short of breath______No Yes
Coughing blood_____No Yes
Painful breathing____No Yes
Stridor_____________No Yes

Chest pain/angina___No Yes
Breathless with activ. No Yes
Palpitations_________No Yes
Profuse sweating____No Yes
Can't lay flat________No Yes
Wake up gasping____No Yes
Swelling of feet_____No Yes
Passing out________No Yes

Abdominal pain_____No Yes
Nausea_____________No Yes
Vomiting____________No Yes

Frequent indigestion No Yes
Belching____________No Yes
Heartburn___________No Yes
Acid reflux__________No Yes
Constipation________No Yes
Diarrhea____________No Yes
Vomiting blood No Yes
Black stools________No Yes
Passing blood_______No Yes
Stool incontinence__No Yes
Hemorrhoids________No Yes
Rectal pain_________No Yes

Painful urination_____No Yes
Blood in urine_______No Yes
Frequent urination___No Yes
Urinary urgency_____No Yes
Incomplete voiding__No Yes
Excessive night urination__________No Yes
Urinary incontinence No Yes

Joint pains_________No Yes
Joint swelling_______No Yes
Body aches_________No Yes
Chronic back pain___No Yes
Weakness _________No Yes
Muscle pain_________No Yes
Tender points_______No Yes
Leg edema_________No Yes
Leg cramps_________No Yes
Chronic neck pain___No Yes
Gait instability______No Yes

Frequent headaches No Yes
Numbness/ tingling No Yes
Neuropathy_________No Yes
Muscle weakness____No Yes
Convulsion/seizures No Yes
Mental state change No Yes
Dizziness___________No Yes
Vertigo_____________No Yes
Memory problems___No Yes
Abnormal gait_______No Yes
Tremors____________No Yes
Fainting spells______No Yes

Depression_________No Yes
Anxiety/Panic attacksNo Yes
Crying______________No Yes

Sadness____________No Yes
Bad mood swings___No Yes
Lack of enjoyment___No Yes
Pessimism__________No Yes
Hallucinations______No Yes
Hyperactivity_______No Yes

Bleeding problems__No Yes
Swollen nodes______No Yes
Anemia (low blood)__No Yes
Frequent infections_No Yes
Varicose veins______No Yes

Skin rashes_________No Yes
Skin itching_________No Yes
Changing moles_____No Yes
Skin sores__________No Yes
Nail/Hair problems___No Yes

Allergies
Allergy to Penicillin__No Yes
Allergy to Sulfas____No Yes
Allergy to Aspirin___No Yes
Allergy to Opiates___No Yes
Other allergies______No Yes

Females Only
Vaginal disch/itching_No Yes
Pelvic pain_________No Yes
Abnormal menses___No Yes
Hot flushes_________No Yes
Profuse sweats_____No Yes
Decreased sex drive No Yes
Breast pain_________No Yes
Breast lump________No Yes
Nipple discharge____No Yes
Hormonal therapy___No Yes

Males Only
Difficulty start streamNo Yes
Slow urination______No Yes
Testicular masses___No Yes
Decreased sex drive No Yes
Problematic erectionsNo Yes

NAME:

DOB:

Name:______________________________ Date:______________ Date of Birth:______________________

A Checklist for Your Medicare Wellness Annual Visit

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

1. During the past 4 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

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 generally 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? 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

5 During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
- ☐ Very heavy
- ☐ Heavy
- ☐ Moderate
- ☐ Light
- ☐ Very light

	Yes	No
6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?	☐	☐
7. Can you shop for groceries or clothes without help?	☐	☐
8. Can you prepare your own meals?	☐	☐
9. Can you do your own housework without help?	☐	☐
10. Can you handle 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 in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

13. How have things been going for you during the past 4 weeks?
   - ☐ Very well - could hardly be better
   - ☐ Pretty good
   - ☐ Good and bad parts about equal
   - ☐ Pretty bad
   - ☐ Very bad - could hardly be worse

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14. Are you having difficulties driving your car?

☐ Yes, often
☐ Sometimes
☐ No
☐ Not applicable, I do not use a car

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

☐ Yes, usually ☐ Yes, sometimes ☐ No

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

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up	☐	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐	☐
Trouble 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. Are you afraid 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 past 4 weeks, 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 for about 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.

How old are you? ☐ 65-69 ☐ 70-79 ☐ 80 or older

Are you male or female? ☐ Male ☐ Female

What is your race? (check one or more than one)

☐ White
☐ Black/African American
☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaskan Native
☐ Hispanic or Latino origin or descent
☐ Other

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