MEDICARE WELLNESS FORMS

PLEASE FILL OUT THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT

Name: _____ DOB: _____

| | |
|---|---|
| How is your overall health? | Excellent Good Fair Poor |
| How confident are you that you can manage most of your health problems? | Confident Somewhat Not Very Confident<br>I don't have any concerns |
| What are your biggest concerns about managing your health?<br>Please check all that apply | I don't have any concerns<br>I live in an unsafe environment<br>Transportation to appointments<br>Financial difficulty paying for services/medications<br>Difficulty taking or remembering to take my medications<br>Difficulty reading or understanding instructions<br>I am lonely or don't have support at home<br>I fall a lot at home |
| How many times in the last 6 months have you been to the Emergency room? | 0 1-2 3-4 5+ I don't know |
| How many times in the past 6 months have you been admitted to the hospital? | 0 1-2 3-4 5+ I don't know |
| How many different prescriptions are you taking?<br>Do you take all the medications prescribed to you?<br>Are you taking any new medication since your last visit? | 0 1-3 4-6 7-10 10+<br>Yes No<br>Yes No |
| Do you or your family have any concerns about your memory. | Yes No |
| **TOBACC0 / ALCHOL AND SUBSTANCE SCREENING** | |
| Do you use any tobacco products? (Cigarettes, pipes, cigars, chew, snuff)<br>If YES, are you interested in quitting?<br>Do you use any illegal drugs, or take any prescription medications that have not been prescribed to you?<br>How many times in the past two weeks have you had 4 or more alcoholic drinks in a day?<br>Do you take any OPIOD MEDICATIONS? PERCOCET, HYDROCODONE… | Yes No<br>Yes No<br>Yes No If YES, please explain<br>1-2 3-4 5+ I don't drink alcohol<br>Yes No |

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| **NUTRITION** | |
| Do you follow a special diet? (low sodium/cholesterol)<br>Do you use any dietary supplements, meal replacement drinks?<br>Do you drink sugar sweetened beverages? (not diet) | Yes No Any other?<br>_____<br>Yes No<br>Yes No If YES, how many each day?<br>____ |
| **PHYSICAL ACTIVITY** | |
| How many days a week do your exercise?<br>How intense is your exercise? | 0 1-2 3-4 5+ I don't know<br>Light Moderate Very Heavy<br>I don't know I don't exercise |
| **SLEEP** | |
| How many hours of sleep do you usually get each night?<br>Do you snore, or has anyone told you that you snore?<br><br>In the past 7 days, how often have you felt sleepy in the day?<br><br>Have you ever been diagnosed with Sleep Apnea, or other sleep disorders?<br>Are you currently using or have you used a C-PAP / BI PAP? | 0-3 4-6 7-10 10+ I don't know<br>Yes No I don't know I am told I snore<br>Often Sometimes Not Often Never<br><br>Yes No I don't know<br><br>Yes No |
| **FUNCTIONAL STATUS ASSESSMENT** | |
| **Activities of Daily living (ADL'S) Circle all that apply** | |
| Which of the following can you do on your own without help?<br><br><br><br>Does someone help you at home?<br>If Yes, please provide Caregiver Name / Contact information<br><br>Many people experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experiences leaking of urine? | BATHE DRESS EAT WALK<br>USE THE RESTROOM<br>TRANSFER IN / OUT OF CHAIRS, ETC…<br>NONE ALL ACTIVITIES<br>Yes No Spouse Children<br>Aide/Caregiver<br><br>Yes No When I cough or sneeze I don't now |
| **Instrumental Activities of Daily Living (IADL'S) Circle all that apply** | |
| Which of the following can you do on your own without help? | Shop for groceries Use the telephone<br>Housework Handle finances Cook<br>Drive / Use Public Transportation<br>Take medications All Activities<br>None |

| **HOME SAFTEY** | |
|---|---|
| What is your housing situation like? Select all that apply | I live alone<br>I live with my spouse<br>I live with one of my children<br>I live in assisted living<br>I live in a nursing home<br>I have housing today, but I am worried about losing housing<br>I do not have housing – I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in the park. |
| Do you have a problem with any of the following at your home?<br><br>Circle all that apply | Bug infestation Mold Lead Paint / Pipes<br><br>Inadequate heat Oven / Stove not working<br><br>No working smoke detectors Water leaks<br><br>None of the above |
| Do you feel safe in your home?<br>Do you have working smoke alarms / carbon monoxide detectors?<br>Do you have throw rugs on your floors?<br>Do you have handrails in your bathroom?<br>Do you have proper lighting in your home?<br>Do you have handrails for your stairs?<br>Do you use seatbelts in vehicles? | Yes No<br>Yes No I don't know<br>Yes No<br>Yes No<br>Yes No<br>Yes No I don't have stairs<br>Yes No I don't ride in vehicles |
| **RISK FOR FALLING** | |
| Which of these assistive devices do you use?<br><br>Do you have trouble with your balance?<br>In the past year, have you fallen 2 or more times, or had one fall with an injury?<br>Are you afraid of falling?<br>Do you have any amputations? | Cane Walker Wheelchair Crutches None Other: _____<br><br>Yes No<br>Yes No<br><br>Yes No<br>Yes No If YES, Where?<br>_____ |

| | |
|---|---|
| **SENSORY ABILITY** | |
| Do you have any problems with your vision?<br><br><br><br>Do you have any problems with your hearing? | Yes No If YES please circle condition<br>Legally Blind Cataracts<br>Diabetic Retinopathy Other: _____<br><br>Yes No If YES please circle condition<br>Partial hearing loss Deaf<br>Use hearing aids<br>Other: _____ |
| **SOCIAL / EMOTIONAL SUPPORT** | |
| How often do you get out and meet with family and friends? | Often Sometimes Almost Never Never |
| Which of the following applies to you? Circle all the apply | I have a supportive family<br>I have supportive friends<br>I participate in church, clubs or other groups<br>I do not have any social / emotional support |
| **ADVANCED DIRECTIVES** | **IF YOU HAVE A COMPLETED LIVING WILL, PLEASE PROVIDE US A COPY FOR YOUR MEDICAL RECORD** |
| Does your family or friends know what you want in an emergency situation or if you could not speak for yourself?<br><br><br><br>Would you like more information? | Yes, I have a living will<br>Yes, I have a power of attorney<br>Yes, I have a POLST<br>Yes, I have a MOLST<br>Yes, I have completed 5 wishes<br>Yes No Unsure |
| **ALLERGIES** | |
| Please list any allergies to medications, foods, or the environment | |
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| MEDICATIONS – PRESCRIPTIONS / VITAMINS / OVER THE COUNTER | |
|---|---|
| **NAME** | DOSE |
| | |
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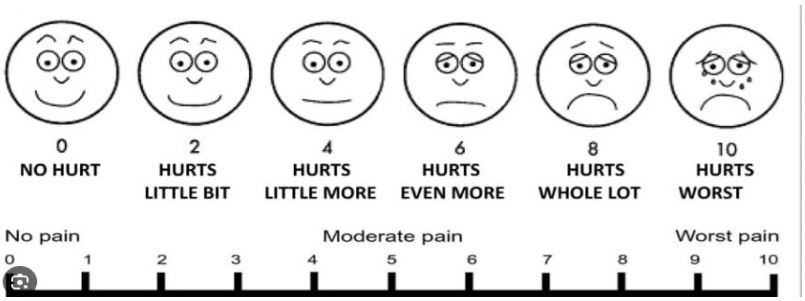
| | |

**PAIN ASSESSMENT**

In the past 2 weeks how often have you felt pain?

PLEASE RATE ANY CURRENT PAIN



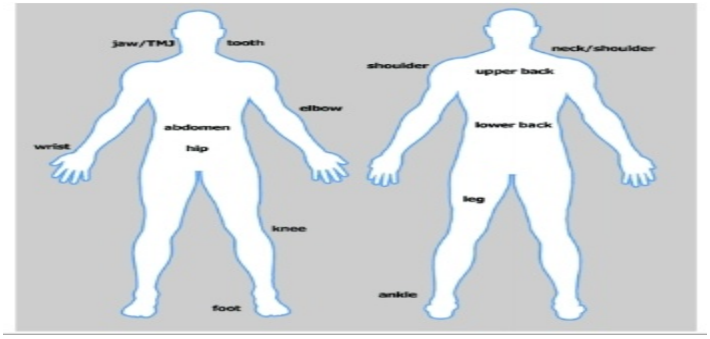

Almost all of the time
Most Times

Sometimes

Almost Never

Never

**Please mark where your pain is**




| Are there any new providers on your Healthcare Team | |
|---|---|
| Physician Name | Specialty |
| | |
| | |
| | |

Please list any updates to your health history or your family health history

| | NONE | SELF | PARENT | SIBLING | CHILD |
|---|---|---|---|---|---|
| HEART DISEASE | | | | | |
| DIABETES | | | | | |
| OBESITY | | | | | |
| MENTAL ILLNESS | | | | | |
| CANCER | | | | | |
| LUNG DISEASE/ASTHMA | | | | | |
| OTHER | | | | | |

DEPRESSION PHQ 9

| **In the past 2 weeks, how often have you been bothered by the following problems:** | **Not at all:** | **Several Days:** | **More than half of those days:** | **Nearly every day:** |
|---|---|---|---|---|
| Little interest or 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're a failure, or have let yourself or 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've been moving around a lot more than usual | **0** | **1** | **2** | **3** |
| Thoughts that you would be better off dead, or of hurting yourself | **0** | **1** | **2** | **3** |
| **Total Score:** | | | | |
| If you checked off any of the problems in this section, 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 at all | Somewhat | Very difficult | Extremely difficult |

For Provider – Please address if the patient is taking Opioids

The patient has been provided information on non-opioid treatment options for pain Yes No

The patient has known misuse of opioids or other risk factors for opioid use disorders Yes No

If clinically indicated, the patient has been offered or referred for specialist care Yes No