MEDICARE WELLNESS CHECKUP

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

Your name: ________________________________

Today’s date: ________________________________

Your date of birth: ________________________________

1. What is your age?
   - 65-69.
   - 70-79.
   - 80 or older.

2. Are you a male or a female?
   - Male.
   - Female.

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 pain have you generally had?
   - No pain.
   - Very mild pain.
   - Mild pain.
   - Moderate pain.
   - Severe pain.

6. 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.

7. 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.

8. 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.

9. Can you go shopping for groceries or clothes without someone’s help?
   - Yes.
   - No.

10. Can you prepare your own meals?
    - Yes.
    - No.

11. Can you do your housework without help?
    - Yes.
    - No.

12. 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.

13. Can you handle your own money without help?
    - Yes.
    - No.

14. During the past four weeks, how would you rate your health in general?
    - Excellent.
    - Very good.
    - Good.
    - Fair.
    - Poor.
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15. 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.

16. Are you having difficulties driving your car?

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

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

- Yes, usually.
- Yes, sometimes.
- No.

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falling or dizzy when standing up.</td>
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<tr>
<td>Sexual problems.</td>
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<td>Trouble eating well.</td>
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<td>Teeth or denture problems.</td>
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<td>Problems using the telephone.</td>
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<tr>
<td>Tiredness or fatigue.</td>
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</tbody>
</table>

19. Have you fallen two or more times in the past year?

- Yes.
- No.

20. Are you afraid of falling?

- Yes.
- No.

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 per 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 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.

25. 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.

26. 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.

27. What is your race? (Check all that apply.)

- White.
- Black or African American.
- Asian.
- Native Hawaiian or other Pacific Islander.
- American Indian or Alaskan Native.
- Hispanic or Latino origin or descent.
- Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.