Name _____ Today's Date _____ Birthdate _____

MEDICARE WELLNESS CHECKUP

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

Answer questions 1-9 as they pertain to the past four weeks

1. How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or down hearted and blue?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely
2. 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. How much bodily pain have you generally had?
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain
4. 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. What was the hardest physical activity you could do for at least two minutes?
   - ☐ Very Heavy
   - ☐ Heavy
   - ☐ Moderate
   - ☐ Light
   - ☐ Very Light
6. How would you rate your health in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
7. 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
8. How often have you been bothered by the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up					
Sexual problems					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					
Tiredness or fatigue					

9. 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 or less drinks per week
   - ☐ No alcohol at all

Name _____ Today's Date _____ Birthdate _____

10. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)
    - ☐ Yes ☐ No
11. Can you go shopping for groceries or clothes without someone's help?
    - ☐ Yes ☐ No
12. Can you prepare your own meals?
    - ☐ Yes ☐ No
13. Can you do your housework without help?
    - ☐ Yes ☐ No
14. 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
15. Can you handle your own money without help?
    - ☐ Yes ☐ No
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, always
    - ☐ Yes, usually
    - ☐ Yes, sometimes
    - ☐ No
18. Have you fallen two or more times in the past year?
    - ☐ Yes ☐ No
19. Are you afraid of falling?
    - ☐ Yes ☐ No
20. Are you a smoker?
    - ☐ No
    - ☐ Yes, and I might quit
    - ☐ Yes, but I'm not ready to quit
21. 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
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 medications 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
25. What is your age?
    - ☐ 65-69 ☐ 70-79 ☐ 80 or older
26. What sex were you assigned at birth?
    - ☐ Male ☐ Female
27. With what gender do you identify?
    - ☐ Male
    - ☐ Female
    - ☐ Other _____
28. What is your sexual orientation?
    - ☐ Heterosexual
    - ☐ Gay
    - ☐ Lesbian
    - ☐ Other _____
29. What is your preferred language?
    - ☐ English
    - ☐ Other _____
30. What is your race?
    - ☐ White
    - ☐ Black/African American
    - ☐ Asian
    - ☐ Native Hawaiian/Pacific Islander
    - ☐ American Indian or Alaska Native
31. Is your ethnicity Hispanic/Latino?
    - ☐ Yes ☐ No

HME Review of Systems

Name: _____ DOB: _____ Date: _____

Exercise: Type _____ Min: _____ Per: Day / Week

Sleep: _____ hrs/night Seat belt: Y/N Tobacco/E-cig: ___/day When start? _____ When quit? _____

Alcohol: _____ drinks/wk Lifetime non-medical drug use: _____

Date of last - Tetanus: _____ Pneumonia: _____ Shingles: _____ Covid complete? Y/N

CURRENT MEDICAL CONCERNS/QUESTIONS: _____

PLEASE CHECK ALL THAT APPLY (Currently or Recently)

- ☐ weight gain
- ☐ weight loss
- ☐ fatigue
- ☐ fever
- ☐ night sweats

- ☐ visual difficulties
- ☐ hearing difficulties
- ☐ ear pain
- ☐ seasonal allergies
- ☐ dental problems

- ☐ chest discomfort
- ☐ rapid or irregular heartbeat
- ☐ swelling in feet/legs

- ☐ cough
- ☐ wheezing
- ☐ shortness of breath
- ☐ snoring
- ☐ sleep apnea

- ☐ nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ abdominal pain
- ☐ change in stool
- ☐ blood in stool
- ☐ reflux/heartburn
- ☐ last colonoscopy/sigmoidoscopy:

_____

- ☐ new/changed headache
- ☐ seizure
- ☐ dizziness
- ☐ passing out
- ☐ numbness/tingling
- ☐ tremor/shakiness
- ☐ memory loss
- ☐ weakness

- ☐ easy bruising/bleeding
- ☐ swollen lymph nodes
- ☐ blood clot

- ☐ rash
- ☐ worrisome moles

MEN:

- ☐ penile discharge
- ☐ weakness of urinary stream
- ☐ nighttime urination
- ☐ number of children _____

WOMEN:

- ☐ pregnancies _____
- ☐ number of children _____
- ☐ number of miscarriages _____
- ☐ number of abortions _____
- ☐ painful/heavy periods
- ☐ irregular periods
- ☐ last mammogram_____
- ☐ last PAP _____
- ☐ menopausal symptoms
- ☐ breast lumps
- ☐ date of last period _____

- ☐ muscle pain
- ☐ joint pain

- ☐ gender identity _____
- ☐ sexual orientation _____

- ☐ urinary incontinence
- ☐ painful urination
- ☐ urinary urge/frequency
- ☐ blood in urine
- ☐ sexual difficulties/concerns

- ☐ suicidal thoughts
- ☐ increased stress
- ☐ difficulty sleeping
- ☐ anxiety/nervousness
- ☐ family/marital issues
- ☐ pushed/shoved/harmed?
- ☐ domestic violence
- ☐ eating disorder (past or present)

- ☐ advanced directives
- ☐ living will
- ☐ power of attorney

Personal goals for the upcoming year: _____

Name: _____ DOB: _____

Social Needs Screening Form

		Yes / No
	In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	Y N
	In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?	Y N
	Are you worried that in the next 2 months, you may not have stable housing?	Y N
	Do problems getting child care make it difficult for you to work or study? *(leave blank if you do not have children at home.)*	Y N
$	In the last 12 months, have you needed to see a doctor, but could not because of cost?	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	Y N
	Do you ever need help reading hospital materials?	Y N
	Do you often feel that you lack companionship?	Y N
!	**Are any of your needs urgent?** For example: I don't have food for tonight, I don't have a place to sleep tonight.	Y N
?	If you checked YES to any boxes above, would you like to receive assistance with any of these needs?	Y N

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. 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 _____

A2663B 10-04-2005