AGE 65+ (or MEDICARE) WELLNESS CHECKUP

Name: _____ Date of Birth_____ Today's Date_____

Please circle your answer

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

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 body pain have you generally been in?
- No pain
- Very mild pain
- Mild pain
- Moderate pain
- Severe pain

6. During the **past four week,** was someone available to help you, if you needed and wanted help?
- 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 that you could do for at least two minutes?
- Very heavy
- Heavy
- Moderate
- Light
- Very light

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

9. 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

10. Are you having difficulties driving your car?
    - Yes, often
    - Sometimes
    - No
    - Not applicable, I do not have a car

11. Have you fallen two or more times in **the past year?** Yes No

12. Are you afraid of falling? Yes No

13. Are you a smoker?
    - No
    - Yes, and I might quit
    - Yes, but I am not ready to quit

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

Always Usually Sometimes Never

15. How often in the **past four weeks,** have you been bothered by any of the following problems?

Falling or dizzy when standing up	Never	Rarely	Sometimes	Often	Always
Sexual problems	Never	Rarely	Sometimes	Often	Always
Trouble eating well	Never	Rarely	Sometimes	Often	Always
Teeth/denture problems	Never	Rarely	Sometimes	Often	Always
Tiredness or fatigue	Never	Rarely	Sometimes	Often	Always

16. How often do you eat foods that are healthy for you? (such as fresh fruits/vegetables, and fish) instead of foods that are not healthy for you (such as fried foods, sweets and "junk foods")?

- Almost always eat healthy meals
- Some of the time eat healthy meals
- A little of the time eat healthy meals
- Almost never eat a healthy meal

17. 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

18. 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

19. 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

20. 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

21. Do you have hearing difficulties? Yes No

22. What is your race? (Circle all the apply)

White	Asian
Black or African American	Native Hawaiian/Pacific Islander
American Indian or Alaskan Native	Other

Suppliers

Please list the suppliers of your Medicare covered equipment and services, including but not limited to home health, physical therapy, prosthetic devices, orthotics, and Durable Medical Equipment such as walkers, wheelchairs, and hospital beds. If none, please write none.

Functional Assessment of Instrumental Activities of Daily Living

Please circle whether you are able to perform the following tasks independently, do you need some help or if you are dependent on others.

Bathing:	Independent	Need some help	Dependent
Dressing:	Independent	Need some help	Dependent
Grooming:	Independent	Need some help	Dependent
Feeding:	Independent	Need some help	Dependent
Phone:	Independent	Need some help	Dependent
Shopping:	Independent	Need some help	Dependent
Housework:	Independent	Need some help	Dependent
Medications:	Independent	Need some help	Dependent
Money management:	Independent	Need some help	Dependent
Walking:	Independent	Need some help	Dependent

Alcohol and Substance Abuse Screening

Please circle "Yes" or "No"

Have you ever felt the need to cut back or control your drinking or drug use? Yes No
Have you ever been annoyed by someone questioning your use of alcohol or drugs? Yes No
Have you ever felt guilty about something you did while drinking or using drugs? Yes No
Have you ever had an eye opener? (A drink or drug first thing in the morning) Yes No

Advanced Directive

Medicare will now pay for you to review with your health care provider your wishes for future health care should you lose the ability to make such decisions. In Texas, it is called MOST(Medical Orders for Scope of Treatment) and is more detailed and complements Advanced Care Planning documents such as Power of Attorney, and Advance Directive/Living Will. We use it in combination with "Five Wishes" making it more user-friendly review of your personal desires/wishes. Should you wish to take advantage of this Medicare-covered service, please circle "YES "so that we can provide you with the documents for your review/completion, and for the scheduling of an office visit for review of these with your health care provider.

YES

Chronic Care Management

If you have two or more chronic conditions (such as diabetes, depression, high blood pressure, high cholesterol, morbid obesity, lung disease, liver disease, cancer, kidney failure, rheumatoid arthritis, etc) you may be eligible for a new Medicare Program called "Chronic Care Management" whereby we will contact you by telephone monthly at a time that is convenient for you to review your medications, problems, results of lab tests, x-rays, consultations, etc. If interested, please circle "YES" so your health care professional can provide additional information for your review and consideration.

YES

_____ _____

Signature Date