What you should bring to your Annual Wellness Visit:

The names of all your doctors:

Name	Specialty

Name of medicine	Dose (if you remember)

Have any of your close relatives had any health changes? ______ Yes ______ No

Has your mood changed? ______ Yes ______ No

Do you worry about falling? ______ Yes ______ No

Are you worried about your memory? ______ Yes ______ No

Are there any preventative tests you have done recently? ______ Yes ______ No
(such as lab tests, mammograms, xrays)

Have you had any recent immunizations? ______ Yes ______ No

Do you have a living will or advance directive?
(if you have one, please bring a copy of it with you.) ______ Yes ______ No

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. Over the last 4 weeks, how often have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day
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. Because of health or physical problem, do you have any difficulty doing the following activities <u>without special equipment or help from another person</u>?

	I do not have difficulty	Yes, I have difficulty
a. Bathing	☐	☐
b. Dressing and grooming	☐	☐
c. Eating	☐	☐
d. Using the toilet	☐	☐
e. Getting In and out of bed to chairs	☐	☐
f. Managing medications	☐	☐
g. Managing money	☐	☐
h. House chores: laundry, food prep, housekeeping	☐	☐

5. If for any reason you have difficulty or cannot do any of the activities listed in Question 4, do you get the help that you need from family, health aides, or assistive devices [ex: Walker, cane, shower chair] ?
   - ☐ I get all the help I need
   - ☐ I could use a little more help
   - ☐ I need a lot more help
   - ☐ I don't need any help
6. <u>During the past 4 weeks</u>, how would you rate your health in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
7. How have things been going for you <u>during the past 4 weeks?</u>
   - ☐ Very well-could hardly be better
   - ☐ Pretty good
   - ☐ Good and bad parts about equal
   - ☐ Pretty bad
   - ☐ Very bad-could hardly be worse
8. Do you have difficulties driving your car?
   - ☐ Yes, often
   - ☐ Sometimes
   - ☐ No
   - ☐ Not applicable, I do not use a car
9. Do you always fasten your seat belt when you are in a car?
   - ☐ Yes, usually
   - ☐ Yes, sometimes
   - ☐ No

	Yes	No
10. A fall is when your body goes to the ground without being pushed. Did you fall 2 or more times in the past year?	☐	☐
11. In the past 12 months, have you had a problem with balance or walking?	☐	☐
12. Do you have a hearing problem, or do others think you have a hearing problem?	☐	☐
13. Do you have tooth, mouth, or denture problems that make it hard to eat?	☐	☐
14. In the last year, have you or any of your friends and family felt concerned about any changes in your memory, attention, language skills, or thinking?	☐	☐
15. Do you have difficulty driving, watching TV, reading, or doing any of your daily activities because of your eyesight?	☐	☐

16. Are you a smoker?
    - ☐ No
    - ☐ Yes, and I am thinking about quitting
    - ☐ Yes, but I am not ready to quit
17. During the past 4 weeks, how may drinks of beer, wine, 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
18. 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
19. Are you currently sexually active?
    - ☐ Yes
    - ☐ No

    If "No", skip to Question 21. Otherwise, answer Question 20.
20. If you are sexually active, do you have questions or are you interested in screening for sexually transmitted disease?
    - ☐ Yes
    - ☐ No
21. Does your home have the following safety concerns?
    a. Absent/Broken smoke alarm? Yes ☐ No ☐
    b. Poor lighting or lack of hand rail on stairs? Yes ☐ No ☐
    c. Slippery flooring in the tub or shower or no grab bars? Yes ☐ No ☐
22. 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
23. 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 ☐ 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