Annual Medicare Wellness Checkup

Please complete this checklist before seeing your primary care provider. Your responses will help you receive the best health and healthcare possible

1. Do you have a living will or an Advanced Directive?
   - ☐ Yes
   - ☐ No
2. 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
3. During the past four weeks, how much bodily pains have you generally had?
   - ☐ No Pain
   - ☐ Very Mild Pain
   - ☐ Mild Pain
   - ☐ Moderate Pain
   - ☐ Severe Pain
4. Can you handle your own money without help?
   - ☐ Yes
   - ☐ No
5. Do you have difficulty paying for your medication?
   - ☐ Yes
   - ☐ No
6. During the past four weeks, how would you rate your health in general?
   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
7. Are you having difficulties driving your car?
   - ☐ Yes, often
   - ☐ Sometimes
   - ☐ No
   - ☐ Not applicable, I do not drive a car
8. Are you a smoker?
   - ☐ Yes
   - ☐ No
9. How often during the past four weeks have you been bothered by any of the following problems?

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

10. Are you afraid of falling?
    - □ Yes
    - □ No

11. Have you had a fall in the last year? If so, did the fall result in an injury?
    - □ Yes, no injury resulted
    - □ Yes, I got injured
    - □ No

12. 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

13. 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

14. 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

15. Have you been given any information to help you keep track of your medications?
    - □ Yes
    - □ No

16. 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

17. Functional Limitations- Please check the boxes below next to what you are able to do, not able to do or find difficult doing

	Able to	Not able to	Finds Difficult to do
Climb Stairs			
Exercise			
Get in and out of Cars			
Go down stairs			
Go up stairs			
Kneel			
Perform activities of Daily living			
Put on socks and shoes			
Walk			
Walk 10 blocks			
Walk as long as I want			
Walk 5 to 10 blocks			

Thank you very much for completing your Medicare Wellness Checkup! Please give the completed form to your provider or your nurse.