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. During the past 4 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

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. During the past 4 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

5 During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
- Very heavy
- Heavy
- Moderate
- Light
- Very light

	Yes	No
6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?	☐	☐
7. Can you shop for groceries or clothes without help?	☐	☐
8. Can you prepare your own meals?	☐	☐
9. Can you do your own housework without help?	☐	☐
10. Can you handle your own money without help?	☐	☐
11. Do you need help eating, bathing, dressing, or getting around your home?	☐	☐

12. During the past 4 weeks, how would you rate your health in general?
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

13. How have things been going for you during the past 4 weeks?
   - Very well - could hardly be better
   - Pretty good
   - Good and bad parts about equal
   - Pretty bad
   - Very bad - could hardly be worse

14. Are you having difficulties driving your car?

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

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

☐ Yes, usually ☐ Yes, sometimes ☐ No

16. How often during the <u>past 4 weeks</u> have you been <u>bothered</u> by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up	☐	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐	☐
Trouble eating well	☐	☐	☐	☐	☐
Teeth or dentures	☐	☐	☐	☐	☐
Problems using the telephone	☐	☐	☐	☐	☐
Tired or fatigued	☐	☐	☐	☐	☐

17. Have you fallen 2 or more times in the past year?

☐ Yes ☐ No

18. Are you afraid of falling?

☐ Yes ☐ No

19. Are you a smoker?

- ☐ No
- ☐ Yes, and I might quit
- ☐ Yes, but I'm not ready to quit

20. During the <u>past 4 weeks</u>, how many drinks of wine, beer 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

21. 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.

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 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

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.

How old are you? ☐ 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

What to bring to your Annual Wellness Visit

Name:_____ **Date of Birth:**_____

The names of all the doctors on your healthcare team including specialists (eye doctor, cardiologist, foot doctor):

Name	Specialty

A bag with all of the medicines you take including over-the-counter drugs, vitamins and herbals:

Name of Medicine	Dose

Name:_____ Date of Birth:_____

The names and locations of your pharmacies:

Name	Location

The name of your home health agency:

_____

The names of your medical equipment supply companies (example: oxygen supplier):

Name of Company	Equipment

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 _____

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Caring FOR YOUR Parents

Checklist of Activities of Daily Living (ADL)

Check the level of function of each activity of daily living listed below. This will help you determine how much assistance an elder needs.

FUNCTION	INDEPENDENT	NEEDS HELP	DEPENDENT	DOES NOT DO
Bathing				
Dressing				
Grooming				
Oral Care				
Toileting				
Transferring				
Walking				
Climbing Stairs				
Eating				
Shopping				
Cooking				
Managing Medications				
Using the Phone				
Housework				
Doing Laundry				
Driving				
Managing Finances				

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