

MEDICARE WELLNESS VISIT TOOLKIT  
MEDICARE WELLNESS CHECKUP

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

Your name: \_\_\_\_\_

Today's date: \_\_\_\_\_

Your date of birth: \_\_\_\_\_

1. What is your age?

- 65-69.  70-79.  80 or older.

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 bodily pain have you generally had?

- No pain.  
 Very mild pain.  
 Mild pain.  
 Moderate pain.  
 Severe pain.

6. During the past four 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.

7. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?

- Very heavy.  
 Heavy.  
 Moderate.  
 Light.  
 Very light.

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)

- Yes.  No.

9. Can you go shopping for groceries or clothes without someone's help?

- Yes.  No.

10. Can you prepare your own meals?

- Yes.  No.

11. Can you do your housework without help?

- Yes.  No.

12. 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?

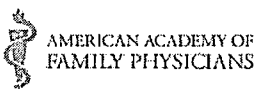
- Yes.  No.

13. Can you handle your own money without help?

- Yes.  No.

14. During the past four weeks, how would you rate your health in general?

- Excellent.  
 Very good.  
 Good.  
 Fair.  
 Poor.



FPM Toolbox To find more resources, please visit <http://www.aafp.org/fpm/toolbox>

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15. 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.

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, usually.
- Yes, sometimes.
- No.

18. 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble eating well.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth or denture problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems using the telephone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness or fatigue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Have you fallen two or more times in the past year?

- Yes.  No.

20. Are you afraid of falling?

- Yes.  No.

21. Are you a smoker?

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

22. 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.

23. 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.

24. 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.

25. 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.

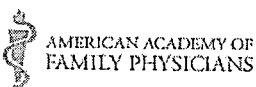
26. How confident are you that you can control and manage most of your health problems?

- Very confident.
- Somewhat confident.
- Not very confident.
- I do not have any health problems.

27. What is your race? (Check all that apply.)

- White.
- Black or African American.
- Asian.
- Native Hawaiian or other Pacific Islander.
- American Indian or Alaskan Native.
- Hispanic or Latino origin or descent.
- Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.



**MEDICARE WELLNESS VISIT TOOLKIT**  
**MEDICARE PREVENTIVE PHYSICAL EXAM**

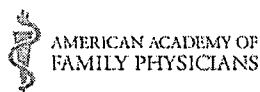
Today's Date \_\_\_\_\_

<input type="checkbox"/> Initial Preventive Physical Exam ("Welcome to Medicare" Physical)		<input type="checkbox"/> Initial annual wellness visit		<input type="checkbox"/> Subsequent annual wellness visit		<input type="checkbox"/> Other	
Patient name			Medical record #			Date of birth	
Staff conducting initial intake			Date of last exam			Medicare B eligibility date	
Language or other communication barriers: (describe)						Sex	LMP
Interpreter or other accommodation provided today: (describe)						Gravida/para	Year of menopause
Vital signs	Ht	Wt	BMI	Waist	BP	Temp	P/R

Patient completed health risk assessment (Annual Wellness Visit requirement only; e.g. [www.medicalhealthassess.org](http://www.medicalhealthassess.org))

SOCIAL HISTORY							
Tobacco	<input type="checkbox"/> Current	Type:	Freq:	<input type="checkbox"/> 2nd hand	<input type="checkbox"/> Never	<input type="checkbox"/> Prior use	Quit date:
ETOH	<input type="checkbox"/> Never	<input type="checkbox"/> Occasional	<input type="checkbox"/> Daily	History of ETOH: (describe)			
Diet notes			Caffeine	<input type="checkbox"/> Never	<input type="checkbox"/> Occasional	<input type="checkbox"/> Daily	
Drug abuse	<input type="checkbox"/> Never	<input type="checkbox"/> Occasional	<input type="checkbox"/> Daily	<input type="checkbox"/> Prior use	Quit date:		
History of drug abuse: (describe)							
Occupation				Exercise type/frequency			
Home environment <input type="checkbox"/> Private home <input type="checkbox"/> Assisted living <input type="checkbox"/> Other: (describe)							

FAMILY HISTORY									
use ✓ to indicate positive history									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart disease									
Stroke									
Kidney disease									
Obesity									
Genetic disorder									
Liver disease									



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 Updated: 8/2016.

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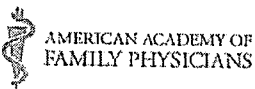
FAMILY HISTORY continued use ✓ to indicate positive history									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Depression or manic depressive disorder									
Colon or rectal cancer									
Breast cancer									
Other cancer									
Other: _____									

MEDICAL HISTORY				
Hospital visits since last office visit/reason	Facility	Attending physician	Date of hospital visit	Past surgeries (include date and description of any complications)

INJURIES (SINCE LAST PHYSICAL EXAM)		
Date	Type	Treatment received

ALLERGY LIST	
Allergies	Type of reaction

MEDICATION LIST if noted elsewhere in chart, indicate location: _____					
Herbals, supplements, OTC drugs, substances of abuse	Date started	Date discontinued	Rx meds, dose, frequency, route	Date started	Date discontinued



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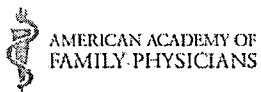
Patient's name: \_\_\_\_\_ Today's date: \_\_\_\_\_

MEDICATION LIST continued					
if noted elsewhere in chart, indicate location: _____					
Herbals, supplements, OTC drugs, substances of abuse	Date started	Date discontinued	Rx meds, dose, frequency, route	Date started	Date discontinued

PROBLEM LIST				
Chronic problems	Date added	Managing physician (if other)	Date updated	Initial
Acute problems (R=resolved)	Date added	Managing physician (if other)	Date updated	Initial

OTHER PHYSICIANS AND PROVIDERS OF CARE		
this documentation not required for IPPE		
Name & specialty/provider type	Type of care	Date discontinued

Physician/other provider sign here to indicate review/notation of pertinent history: \_\_\_\_\_



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