# MEDICARE WELLNESS CHECKUP

Family Practice Management

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: _____

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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.

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. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sexual problems. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Trouble eating well. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Teeth or denture problems. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Problems using the telephone. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tiredness or fatigue. | ☐ | ☐ | ☐ | ☐ | ☐ |

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

Family Practice Management

Today's Date _____

| ☐ Initial Preventive Physical Exam ("Welcome to Medicare" Physical) | ☐ Initial annual wellness visit | ☐ Subsequent annual wellness visit | ☐ 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)

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

| FAMILY HISTORY<br>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 | | | | | | | | | |

# MEDICARE PREVENTIVE PHYSICAL EXAM



Patient's name: _____ Today's date: _____

| 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) |
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| INJURIES (SINCE LAST PHYSICAL EXAM) | | |
|---|---|---|
| Date | Type | Treatment received |
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| ALLERGY LIST | |
|---|---|
| Allergies | Type of reaction |
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| 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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# MEDICARE PREVENTIVE PHYSICAL EXAM



Patient's name: _____ Today's date: _____

| MEDICATION LIST continued<br>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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| PROBLEM LIST | | | | |
|---|---|---|---|---|
| Chronic problems | Date added | Managing physician (if other) | Date updated | Initial |
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| **Acute problems (R=resolved)** | **Date added** | **Managing physician (if other)** | **Date updated** | **Initial** |
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| OTHER PHYSICIANS AND PROVIDERS OF CARE<br>this documentation not required for IPPE | | |
|---|---|---|
| Name & specialty/provider type | Type of care | Date discontinued |
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☐ Physician/other provider sign here to indicate review/notation of pertinent history: _____