Your health before your wellness visit

Please answer these questions before your Medicare Annual Wellness Visit. It takes about 15 minutes. Skip any question you prefer not to answer. Someone may help you fill it in. Bring it with you, and your care team will go over it with you.

ABOUT YOU

Name _____

Date of birth _____

Today's date _____

Gender _____

Race and ethnicity, in your own words _____

Preferred language _____

Who filled in this form?

☐ I did ☐ Someone helped me ☐ Someone filled it in for me

YOUR HEALTH

In general, how would you rate your health?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Compared with a year ago, your health is

☐ Better ☐ About the same ☐ Worse

In the past year, how many times have you stayed overnight in a hospital?

☐ None ☐ Once ☐ Two or more times

Do you feel you have become weaker, slower or more tired over the past year?

☐ No ☐ A little ☐ A lot

Can you walk a quarter of a mile (about two blocks) without stopping?

☐ Yes, easily ☐ Yes, with difficulty ☐ No

Can you climb a flight of stairs without resting?

☐ Yes, easily ☐ Yes, with difficulty ☐ No

HOW YOU HAVE BEEN FEELING

Over the past two weeks:

How often have you felt down, depressed or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

How often have you had little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

How often have you felt stressed, worried or on edge?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

How often have you felt angry or irritable?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

How often have you felt lonely or cut off from other people?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

How much has pain gotten in the way of your daily life?

☐ Not at all ☐ A little ☐ Quite a bit ☐ A lot

How often have you felt too tired to do what you want to do?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

YOUR LIFE

Overall, how satisfied are you with your life?

☐ Very satisfied ☐ Satisfied ☐ Not very satisfied ☐ Not at all satisfied

YOUR HABITS AND SAFETY

Do you smoke or use tobacco or nicotine products, including e-cigarettes?

☐ Never ☐ I used to ☐ Yes, now

How many days a week do you drink alcohol?

☐ None ☐ 1 or 2 ☐ 3 to 5 ☐ 6 or 7

On a day you drink, how many drinks do you usually have?

☐ I don't drink ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 or more

How many days a week are you physically active for at least 30 minutes (walking, gardening, exercise)?

☐ None ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or more

How many servings of fruit and vegetables do you eat on a typical day? (A serving is about a handful.)

☐ None ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or more

Do you have trouble chewing or swallowing, or pain in your mouth or teeth?

☐ No ☐ Yes

When did you last see a dentist?

☐ Within a year ☐ 1 to 2 years ago ☐ More than 2 years ago

Do you have any questions or concerns about your sexual health?

☐ No ☐ Yes ☐ Prefer not to say

Do you always wear a seat belt in a car?

☐ Yes ☐ No

Do you drive?

☐ Yes ☐ No

Have you fallen in the past year?

☐ No ☐ Once ☐ Two or more times

Are you afraid of falling?

☐ No ☐ Yes

Do you have trouble with your balance or feel unsteady when you walk?

☐ No ☐ Sometimes ☐ Often

Do you have working smoke detectors at home?

☐ Yes ☐ No ☐ Not sure

At home, are your rugs, stairs and lighting safe to walk on?

☐ Yes ☐ No ☐ Not sure

Do you feel safe where you live?

☐ Yes ☐ No

EVERYDAY ACTIVITIES

Can you do these on your own?

Get dressed

☐ Without help ☐ With some help ☐ Cannot do

Eat

☐ Without help ☐ With some help ☐ Cannot do

Use the toilet

☐ Without help ☐ With some help ☐ Cannot do

Groom yourself (brush teeth, comb hair)

☐ Without help ☐ With some help ☐ Cannot do

Bathe or shower

☐ Without help ☐ With some help ☐ Cannot do

Walk across a room

☐ Without help ☐ With some help ☐ Cannot do

Get in and out of a bed or chair

☐ Without help ☐ With some help ☐ Cannot do

RUNNING YOUR HOME

Can you do these on your own?

Shop for groceries and other things you need

☐ Without help ☐ With some help ☐ Cannot do

Prepare your own meals

☐ Without help ☐ With some help ☐ Cannot do

Use the telephone

☐ Without help ☐ With some help ☐ Cannot do

Do housework

☐ Without help ☐ With some help ☐ Cannot do

Do laundry

☐ Without help ☐ With some help ☐ Cannot do

Get to places beyond walking distance

☐ Without help ☐ With some help ☐ Cannot do

Take your medicines correctly and on time

☐ Without help ☐ With some help ☐ Cannot do

Manage your money and pay bills

☐ Without help ☐ With some help ☐ Cannot do

How do you usually get to appointments?

☐ I drive ☐ Someone drives me ☐ Public transport ☐ Other

ANYTHING ELSE

Do you have trouble hearing, even with hearing aids?

☐ No ☐ Yes

Have you or anyone close to you noticed changes in your memory or thinking?

☐ No ☐ Yes ☐ Not sure

What would you most like to talk about at your visit?