



Medicare Wellness Form

Please complete this checklist before your appointment, and bring it in with you.

During the past **4 weeks** How much bodily pain have you generally had?

No Pain. Very Mild Pain. Mild Pain. Moderate Pain. Severe Pain.

Where is the pain located? _____

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.

Can you get places outside of walking distance without help? For example, can you travel alone by bus, taxi or drive your own car?

Yes. No.

Can you shop for groceries or clothes without help?

Yes. No.

Can you prepare your own meals?

Yes. No.

Can you do your own housework without help?

Yes. No.

Can you handle your own money without help?

Yes. No.

Do you need help eating, bathing, dressing or getting around your home?

Yes. No.

Do you feel you have a good support system to help you if you need it?

Yes. No.

During the past **4 weeks** how would you rate your health in general?

Excellent. Very good. Good. Fair. Poor.

During the past **4 weeks** how have things been going for you?

Very well. Pretty good. Equally good and bad. Pretty bad. Very bad.

Are you having difficulties driving your car?

Yes, often. Sometimes. No. I do not use a car.

Do you fasten your seatbelt when you are in a car?

Yes, always. Sometimes. No.

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

Yes. No.

Are you afraid of falling?

Yes. No.

Do you exercise for about 20 minutes 3 or more times a week?

Yes, most of the time. Some of the time. Not usually. No.

Name _____

Date of Birth _____

How often during the past **4 weeks** have you been bothered by the following problems

	Never	Less than 1/2 of the days	More than 1/2 of the days	Daily
Feeling dizzy when standing up				
Sexual problems				
Difficulty eating				
Tooth or denture difficulties				
Difficulty using a telephone				
Difficulty Hearing				
Feeling more tired/fatigued				
Forgetting to take medication				
Difficulty with bowel/bladder				

Are you worried about your memory?

Yes. I am not but my family/friends are. There are no concerns.

How confident are you in managing most of your health problems?

Very Confident. Somewhat Confident. Not Confident. I have no health problems.

Do you have a Medical Power of Attorney?

Yes, and I believe you have it on file. Yes, and I brought it today. No.

Do you have a Living Will?

Yes, and I believe you have it on file. Yes, and I brought it today. No.

Anything specific you want to address today? **Additional questions can be brought up but may require an additional office visit.

Name _____

Date of Birth _____