Medicare Wellness Checkup

Today's date: _____ / _____ / _____

Your Name: _____

Your Date of Birth: _____ / _____ / _____

Age ☐ Under 65 ☐ 65-69 ☐ 70-79 ☐ 80 or older
Gender ☐ Male ☐ Female

1. During the past four weeks, how much bodily pain have you generally had?
   ☐ No pain ☐ Very mild pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain

2. 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

3. 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

4. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?) ☐ Yes ☐ No

5. Can you go shopping for groceries or clothes without someone's help? ☐ Yes ☐ No

6. Can you prepare your own meals? ☐ Yes ☐ No

7. Can you do your housework without help? ☐ Yes ☐ No

8. 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

9. Can you handle your own money without help? ☐ Yes ☐ No

10. During the past four weeks, how would you rate your health in general?
    ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

11. 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

12. Are you having difficulties driving your car?
    ☐ Yes, often ☐ Sometimes ☐ No ☐ Not applicable, I do not use a car

13. Do you always fasten your seat belt when you are in a car?
☐ Yes, usually ☐ Yes, sometimes ☐ No

14. How often during the past four weeks have you been bothered by any of the following problems?

Falling/dizzy when standing up	☐ Never	☐ Seldom	☐ Sometimes	☐ Often	☐ Always
Sexual problems	☐ Never	☐ Seldom	☐ Sometimes	☐ Often	☐ Always
Teeth of denture problems	☐ Never	☐ Seldom	☐ Sometimes	☐ Often	☐ Always
Problems using the telephone	☐ Never	☐ Seldom	☐ Sometimes	☐ Often	☐ Always

15. How you fallen two or more times in the past year? ☐ Yes ☐ No

16. Are you afraid of falling? ☐ Yes ☐ No

17. Are you a smoker? ☐ No ☐ Yes, and I might quit ☐ Yes, but I'm not ready to quit

18. 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

19. 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

20. 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 medication? ☐ Yes ☐ No

21. 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

22. 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