THOMPSON MEDICAL ASSOCIATES

Internal Medicine and Concierge Medicine

Patient's name: _____ **DOB:** _____

Medicare Wellness Short Questionnaire

Please answer the following questions to the best of your ability.

1. How would you rate your overall health, quality of life, and mental health?

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

2. In the past week, how much did pain affect your daily activities?

☐ Not at all	☐ A little bit	☐ Somewhat	☐ Quite a bit	☐ Very much

3. Over the **last two weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐

4. Do you smoke or vape nicotine? ☐ Yes ☐ No

5. How many alcoholic drinks per week?
☐ 10+ ☐ 6 – 9 ☐ 2 – 5 ☐ 1 or less ☐ 0

6. In the past 6 months, have you accidentally leaked urine? ☐ Yes ☐ No

7. Have you fallen in the past year? ☐ Yes ☐ No
If yes, how many times?_____Were you Injured? _____

8. Walking status: ☐ Walk unassisted ☐ Use a cane or walker ☐ Use a wheelchair

9. Can you walk at a fast pace for 2 minutes? ☐ Yes ☐ No

10. Do you regularly exercise at 3 least days a week? ☐ Yes ☐ No

11. Do you use a seat belt? ☐ Yes ☐ No

12. Any hearing problems? ☐ Yes ☐ No

13. Any visual problems affecting daily activities? ☐ Yes ☐ No

14. Because of a health or physical problem, do you have any difficulty doing the following activities **without special equipment or help from another person**

	I do not have difficulty	Yes, I have difficulty	I am not able to do this activity unassisted
Bathing			
Dressing and grooming			
Eating			
Using the toilet			
Getting in and out of bed or chairs			
Managing medications			
Managing money			
Household activities, like food prep, laundry, and housekeeping			
Can you shop for groceries and clothes?			
Can you get to places out of walking distance?			

15. Does the place where you live have the following safety concerns addressed?

	Yes	No
Loose rugs secured	☐	☐
Carbon Monoxide detector	☐	☐
Working smoke alarm	☐	☐
Good lighting in walkways	☐	☐
Solid hand rails on stairs	☐	☐
Non-slip flooring in tub or shower, or grab bars	☐	☐

16. What is your usual form of transportation?

☐ Drive self	☐ Driven by others	☐ Bus/taxi/paratransit

17. Do you have the following?

	Yes	No
Advance Healthcare Directive or Health Care Proxy (HCP)	☐	☐
Is the file with us?	☐	☐
Medical Orders for Life-Sustaining Treatment (MOLST) – pink form	☐	☐

18. List of providers you regularly see:

_____

_____

_____

Print name (not signature): _____