Patient Name: _____Today's Date:_____ Date of Birth:_____

**MEDICARE WELLNESS APPOINTMENT: (circle one)** **Initial—age 65** **1st well check** **subsequent well check**

**Have there been any changes in Family History—any new diagnosis of cancer or heart disease for example?** _____

**Have you looked over your med list and made appropriate changes?** _____

**Are you allergic to any medications? If so, what drug and what type of reaction?** _____

_____

**Have you been in the hospital since your last visit here? Why?** _____

**We show that you see the following specialists—please make appropriate changes:**

| Doctor's Name | Specialty | Reason for Appt | Doctor's Name | Specialty | Reason for Appt |
|---|---|---|---|---|---|
| : | | | | | |

_____
_____
_____
_____
_____

**If you are under the care the care of a cardiologist when was your last appointment?** _____

**Have they done and EKG in the past year/ or have you had one elsewhere?** _____ **If so, when/ where?** _____

**When was your last formal eye exam?** _____ **By Whom?** _____

***(Vision Screen: Left:*** _____ ***Right:*** _____ ***Corrected?*** _____***)***

**Have you noticed any difficulty hearing?** _____ **Is this getting worse?** _____

**When was the last time you had your hearing checked?** _____

**Future planning:**

**Do you have advanced directives in place?** _____ **If so, who has a copy?** _____

**Do you have a will in place?** _____

**Do you feel you need any help with: Phone**_____ **Transportation**_____ **Shopping/ Groceries**_____

**Preparing Meals**_____ **Housework**_____ **Laundry** _____ **Taking medications**_____

**Money/ Paying bills**_____ **Do you have enough food?** _____ **Do you have heat/ air conditioning?** _____

Name:_____ Date:_____ Date of Birth:_____

**Medicare Wellness: Health Risk Assessment**

1. In general, would you say your health is:
___ Excellent___ Very Good ___ Good ___ Fair ___ Poor

2. How have things been going for you during the past 4 weeks?
___ Very well; could hardly be better
___ Pretty well
___ Good and bad parts about equal
___ Pretty bad
___ Very bad; could hardly be worse

3. How confident are you that you can control and manage most of your health problems/issues?
___ Very confident
___ Some what confident
___ Not very confident
___ I do not have any health problems

4. How often in the last 4 weeks have you been bothered by any of the following problems?

| | Never | Seldom | Sometimes | Often | Always |
|---|---|---|---|---|---|
| Falling or dizzy when standing up | | | | | |
| Sexual problems or concerns | | | | | |
| Trouble eating well | | | | | |
| Teeth or denture problems | | | | | |
| Problems using the telephone | | | | | |
| Tiredness or fatigue | | | | | |
| Problems sleeping | | | | | |

5. Have you fallen two or more times in the past year? ___ YES ___ NO

6. Are you afraid of falling? Do you feel unsteady? ___ YES ___ NO

7. HOME SAFETY CHECKLIST
   Are entrance ways well lit? ___ YES ___ NO
   Are sidewalks/entrance ways maintained? ___ YES ___ NO
   Is a carbon monoxide detector installed? ___ YES ___ NO
   Are smoke detectors installed? ___ YES ___ NO
   Are all medicines kept in original containers with original labels intact? ___ YES ___ NO
   Do you throw out all unidentified or out-of-date medications? ___ YES ___ NO

8. 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 directed
   ___ Sometimes I take them as directed
   ___ I seldom take them as directed

9. Are you having difficulties driving your car? ___ Yes, often ___ Sometimes ___ No ___ N/A – I do not use a car

10. Do you always fasten your seat belt when you are in a car?
___ Yes, always/usually
___ Yes, sometimes
___ No

11. How often in the last 4 weeks have you experienced the following:

HEARING LOSS SCREENING

| | Never | Seldom | Sometimes | Often | Always |
|---|---|---|---|---|---|
| Straining to understand conversation | | | | | |
| Trouble hearing in a noisy background | | | | | |
| Misunderstanding what others are saying | | | | | |

12. During the past 4 weeks how much have you been bothered by feelings of anxiety, depression, irritability or sadness?
___ Not at all ___ Quite a bit ___ Slightly ___ Moderately ___ Extremely

13. During the past 4 weeks, has your physical or emotional health limited your social activities with family and friends?
___ Not at all ___ Quite a bit ___ Slightly ___ Moderately ___ Extremely

14. During the past 4 weeks, how much bodily pains have you generally had?
___ No Pain ___ Very Mild Pain ___ Mild Pain ___ Moderate Pain ___ Severe Pain

15. Do you have someone who is available to help you if you needed or wanted help?
___ Yes, as much as I want / need
___ Yes, some
___ No, not at all

16. Because of any health problems, do you need the help of another person with shopping, preparation of meals, or house work?
___ Yes ___ No

17. 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

18. Can you handle your own money without help?
___ Yes ___ No

19. During the past 4 weeks, did you exercise for about 20 minutes, 3 or more days a week?
___ Yes, most of the time
___ Yes, some of the time
___ No, I usually do not exercise this much
___ No, I am not currently exercising

20. When you exercise, how intensely to you typically exercise?
___ Light (stretching/slow walking)
___ Moderate (brisk walking)
___ Heavy (jogging/swimming)
___ Very Heavy (running/stair climbing)

21. Are you a smoker/tobacco user?
___ No – never
___ No – former
___ Yes, and I am interested in quitting
___ Yes, but I'm not ready to quit

22. In the past 7 days, on how many days did you drink alcohol? _____ days

23. On days when you drank alcohol, how often did you have 4 or more drinks?
___ Never
___ Once during the week
___ 2-3 times during the week
___ More than 3 times during the week

Thank you for completing this Medicare Wellness Health Risk Assessment.