MEDICARE WELLNESS QUESTIONNAIRE

Name:_____ Date of Birth_____

Please circle your answers.

Cognitive Impairment

Are you concerned about memory loss? YES NO

How often has confusion/memory loss interfered with your ability to work, volunteer or engage in social activities?

Never Rarely Sometimes Usually Always

In the past 30 days, how often has a family member/friend provided care or assistance for you because of confusion or memory loss?

Never Rarely Sometimes Usually Always

Functional Status/ Actives of Daily living

Do you have difficulty getting out of a chair or car without assistance? YES NO

Do you use a cane or walker? YES NO

Do people complain that you turn the TV volume too high? YES NO

Do you find yourself asking people to repeat themselves? YES NO

Do you have trouble hearing in a noisy room? YES NO

Do you have concerns about your Vision? YES NO

Do you need help with eating, bathing, getting dressed or using the toilet? YES NO

Do you need help with shopping or preparing meals? YES NO

Do you need help with managing money? YES NO

DO you need help with managing your medication? YES NO

Depression Screening

Over the past two weeks, have you been bothered by any of the following problems?

Little interest or pleasure in doing things? Yes No

Feeling down, depressed or hopeless? Yes No

Fall Risk

Have you fallen in the last 12 months? YES NO

If yes, how many times? _____

Tobacco Use

Circle one: None Current Use Past Use

If current use, Type of product: Smoke Smokeless

How much per day_____ How long? _____ Interested in discussing quitting? YES NO

Alcohol Use:

In the past 4 weeks how many drinks of wine, beer or other alcoholic beverages per week?

None <1 2-5 6-9 10 +

Screening and Immunizations

Date of last:

Mammogram: _____

Colon cancer screening: colonoscopy_____ Stool testing_____

Prostate Cancer screening: _____

Influenza: _____

Pneumonia Vaccine: _____

Tetanus/Pertussis _____

Shingles Vaccine _____

Advanced Directive:

Do you have an Advanced Directive? Yes No Never heard of it

Do you have a POLST (Physician Orders for Life Sustaining Treatment) Yes No Never heard of it.

If yes, please bring a copy for your medical records.

Other healthcare providers you see on a regular basis

Name_____ Specialty _____

Name_____ Specialty _____

Name_____ Specialty _____

Name_____ Specialty _____

Any recent hospitalizations, surgery or other conditions since your last visit here?

_____

_____

_____

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