Annual Medicare Exam

Name: _______________________________ **Date of Birth:** ________________ **Date of Exam:** _______________

Patients are entitled to an Annual Medicare Exam; this is to be scheduled within a calendar year of your last exam. Please answer all questions to your best ability as it applies to your current health. We thank you for taking the time to answer these questions.

Demographics:

Marital Status: ____________ How many children do you have? ________ Employment Status: _______________

Living Situation: With spouse/family With Friend/Roommate In a nursing home Alone

How would you best describe your ethnicity? *Please circle what applies.*

American Indian or Alaskan Native	Asian or Asian American	Black or African American
Hawaiian or Pacific Islander	Hispanic or Latino	Non- Hispanic White

Smoking Status:

Have you ever smoked? _____ Year quit: _______

Do you currently smoke? _____ If yes, How many a day? ________

Other tobacco use: ______________________ Do you use any illicit drugs? ____

Social Habits *Please circle what applies.*

Alcohol Consumption:	Never	Daily	Weekly	Socially
Exercise:	Never	Rarely	Often	Daily
Caffeine Consumption:	Never	Rarely	Often	Daily
Seat Belt Use:	Always	Sometimes	Never	
Daily Stress Level:	None	Low	Mild	Moderate/High

Mental Health Assessment: *Please circle what best applies.*

In the past two weeks, how often have you felt …?

Depressed:	Never	Rarely	More Than Half	Every Day
Anxious:	Never	Rarely	More Than Half	Every Day

In the past two weeks, how often have you had…?

Trouble Falling Asleep:	Never	Rarely	More Than Half	Every Day
Lack of Energy:	Never	Rarely	More Than Half	Every Day
Lack of pleasure doing things:	Never	Rarely	More Than Half	Every Day

General Health/ Pain Assessment: *Please circle what best applies.*

In the past month, how often…?

Did you experience pain?	Never	Rarely	Frequently	Daily
Has pain affected your ability to work?	Never	Rarely	Frequently	Daily
Has pain affected your relationships?	Never	Rarely	Frequently	Daily
Has pain affected your ability to walk?	Never	Rarely	Frequently	Daily

On a scale of 1–10, how would you rate your average daily pain? __________

Activities of Daily Life: ***Please circle what best applies.***

How would you describe your ability to…?

Prepare meals:	Very Easy	Easy	Somewhat Difficult	Difficult	Unable To
Bathe yourself:	Very Easy	Easy	Somewhat Difficult	Difficult	Unable To
Toilet independently:	Very Easy	Easy	Somewhat Difficult	Difficult	Unable To
Dress yourself:	Very Easy	Easy	Somewhat Difficult	Difficult	Unable To
Shop for yourself:	Very Easy	Easy	Somewhat Difficult	Difficult	Unable To
Move around your home:	Very Easy	Easy	Somewhat Difficult	Difficult	Unable To
Pay your own bills:	Very Easy	Easy	Somewhat Difficult	Difficult	Unable To
Complete routine housework:	Very Easy	Easy	Somewhat Difficult	Difficult	Unable To

Home Safety/ Assistance:

Do you feel safe in your current home? Yes No

Do you feel living elsewhere would be good for you? Yes No

How much help do you feel you need at home? None A Little Quite a Bit Daily Assistance

How much does your family help with daily or routine chores? Not At All A Little Significantly

Do you use any assistive devices? No Cane Walker Wheelchair Other______________

Are you afraid of falling? Yes No

How many times have you fallen in your home? _________

How many times have you fallen in the past year? _________

Preventative Medicine:

Do you have any Advance Directives? _____ a living will _______ a Medical Power of Attorney

If no, would you like any information on this? _________

Are you satisfied with yourself? Yes No

How would you rate your overall health? Excellent Very Good Good Fair Poor