**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 SometimesNever

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: VeryEasy 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

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