Name:______________________________ Date:______________ Date of Birth:_______________________

A Checklist for Your Medicare Wellness Annual Visit

Please complete this checklist before seeing your doctor or nurse. Your answers will help you receive the best health care possible.

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

2. During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

3. During the past 4 weeks, how much bodily pain have you generally had?

- ☐ No pain
- ☐ Very mild pain
- ☐ Mild pain
- ☐ Moderate pain
- ☐ Severe pain

4. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.

- ☐ Yes, as much as I wanted
- ☐ Yes, quite a bit
- ☐ Yes, some
- ☐ Yes, a little
- ☐ No, not at all

5 During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?

- ☐ Very heavy
- ☐ Heavy
- ☐ Moderate
- ☐ Light
- ☐ Very light

	Yes	No
6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?	☐	☐
7. Can you shop for groceries or clothes without help?	☐	☐
8. Can you prepare your own meals?	☐	☐
9. Can you do your own housework without help?	☐	☐
10. Can you handle your own money without help?	☐	☐
11. Do you need help eating, bathing, dressing, or getting around your home?	☐	☐

12. During the past 4 weeks, how would you rate your health in general?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

13. How have things been going for you during the past 4 weeks?

- ☐ Very well - could hardly be better
- ☐ Pretty good
- ☐ Good and bad parts about equal
- ☐ Pretty bad
- ☐ Very bad - could hardly be worse

14. Are you having difficulties driving your car?
- ☐ Yes, often
- ☐ Sometimes
- ☐ No
- ☐ Not applicable, I do not use a car

15. Do you always fasten your seat belt when you are in a car?
☐ Yes, usually ☐ Yes, sometimes ☐ No

16. How often during the past 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up	☐	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐	☐
Trouble eating well	☐	☐	☐	☐	☐
Teeth or dentures	☐	☐	☐	☐	☐
Problems using the telephone	☐	☐	☐	☐	☐
Tired or fatigued	☐	☐	☐	☐	☐

17. Have you fallen 2 or more times in the past year?
☐ Yes ☐ No

18. Are you afraid of falling?
☐ Yes ☐ No

19. Are you a smoker?
- ☐ No
- ☐ Yes, and I might quit
- ☐ Yes, but I'm not ready to quit

20. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have?
- ☐ 10 or more per week
- ☐ 6-9 per week
- ☐ 2-5 per week
- ☐ 1 drink or less per week
- ☐ No alcohol at all

21. Do 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.

22. Have you been given any information to help you with the following:
- Hazards in your house that might hurt you?
  ☐ Yes ☐ No
- Keeping track of your medications?
  ☐ Yes ☐ No

23. 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 prescribed
- ☐ Sometimes I take them as prescribed
- ☐ I seldom take them as prescribed

24. How confident are you that you can control and manage most of your health problems?
- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ I do not have any health problems.

25. Have you received a flu shot this season?
- ☐ Yes, location (doctor office, CVS, work, etc.): ______________________________
- ☐ No (decline/refusal)

How old are you? 65-69 70-79 80 or older
Are you male or female? ☐ Male ☐ Female
What is your race? (check one or more than one)
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific
- ☐ Islander American Indian/Alaskan
- ☐ Native Hispanic or Latino origin or descent
- ☐ Other

Patient Signature:____ Date:______________________

Date of Service: ______________________

Social Determinants of Health

Patient Name: ____ **Date of Birth:** ____________________________________

As part of your visit today we would like to help with other resources for you and/or your family to maintain your health. We know that factors at home may influence your ability to be healthy. Some examples of these include access to food, housing, utilities, and transportation. Some of the questions may be personal but your answers will be kept confidential and the information is used only to help with offering resources. Our goal is to help you be healthy and have the resources to do just that.

Category	Questions	Responses (circle your answer)
Education	Do you ever need help finding a local career center and/or job training?	Yes No
Education	Do you ever need help reading hospital materials?	Yes No
Education	What is the highest level of school that you have completed?	None Elementary/Middle School High School College Graduate/Professional School
Financial Resource Strain	How hard is it for you to pay for the basics, like food, housing, medical care, and heating?	Very Hard Hard Somewhat Hard Not Very Hard Not Hard at All Patient Refused
Food	Within the past 12 months, has the food you bought just didn't last and you didn't have money to get more?	Never True Sometimes True Often True Patient Refused
Food	Within the past 12 months, have you worried that your food would run out before you got money to buy more?	Never True Sometimes True Often True Patinet Refused
Intimate Partner Violence	Within the last year, have you been afraid of someone close to you?	Yes No
Intimate Partner Violence	Within the last year, have you been humilated or emotionally abused in other ways by someone close to you?	Yes No
Intimate Partner Violence	Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by someone close to you?	Yes No
Intimate Partner Violence	Within the last year, have you been raped or forced to have any kind of sexual activity by someone close to you?	Yes No
Physical Activity	On average, how many days per week do you engage in moderate to strenuous exercise?	0 Days 1 Day 2 Days 3 Days 4 Days 5 Days 6 Days 7 Days

Date of Service: ______________________

Social Determinants of Health

Category	Questions	Responses (circle your answer)
Physical Activity	On average, how many minutes per session do you engage in exercise at this level?	0,10,20,30,40,50,60,70,80,90,100,110,120,130,140,150+ Patient Refused
Social Connection & Isolation	Are you now married, widowed, divorced, separated, never married or living with a partner?	Married Widowed Divorced Separated Never Married Living with a partner Patient Refused Not Asked
Social Connection & Isolation	How often do you attend church or religious services?	Never 1 - 4 times per Year More than 4 Times per Year
Social Connection & Isolation	How often do you attend meetings for the clubs or organizations you belong to?	Never 1 - 4 times per Year More than 4 Times per Year Patient Refused
Social Connection & Isolation	How often do you feel isolated from others?	Never Rarely Sometimes Often Always
Social Connection & Isolation	How often do you get together with the friends or relatives?	Never 1 Time per Week 2 Times per Week 3 Times Per Week More than 3 Times per Week Patient Refused
Social Connection & Isolation	In a typical week, how many times do you talk on the telephone with family, friends, or neighbors?	Never 1 Time per Week 2 Times per Week 3 Times Per Week More than 3 Times per Week Patient Refused
Social Connection & Isolation	In the last 4 weeks, did getting elder care or child care make it difficult to work or study?	Yes No
Stress	How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled.	Not at all Only a Little To Some Extent Rather Much Very Much Patient Refused
Transportation	In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?	Yes No Patient Refused

Date of Service: ______________________

Social Determinants of Health

Category	Questions	Responses (circle your answer)
Transportation	In the past 12 months, has lack of transportation kept you from meetings, work or from getting things needed for daily living?	Yes No Patient Refused
Assistance	Do you want assistance?	Yes No
Assistance	Is it urgent?	Yes No
Depression	Over the past 2 weeks, how often have you felt down, depressed, or hopeless?	Not at all Several Days More than half the days Nearly Every Day
Depression	Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?	Not at all Several Days More than half the days Nearly Every Day

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING ___0___ + ______ + ______ + ______

=Total Score: ______

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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