Medicare Wellness Questionnaire

Name: _____ DOB: _____

Chart #: _____ Date: _____

1. Do you live alone? (If yes go to question 3) Y N
    a. If no, who is at home? _____
    b. What is your living arrangement – Private Home/Assisted Living/etc:
    _____
2. Do you manage your own finances, medications, prepare meals? Y N
    a. If no, who helps you? _____
3. Are you able to get yourself in/out of bed, to the toilet, dressed? Y N
    a. If no, who helps you? _____
4. Do you still drive? Y N
    a. Do you have any concerns about your driving? Y N
5. Have you fallen this last year? Y N
    a. Do you use a walker or cane? Y N
6. Do you use Oxygen at home to help you breathe? Y N
    a. If yes when do you use it? (circle answer) Always With Activity Night only
7. Do you wear glasses? Y N
    a. If yes, who is your eye doctor? _____
    b. Did you have an appointment this year with that doctor? Y N
    c. Do you wear hearing aids? Y N
    d. Do you feel you may need them? Y N
8. Have you ever smoked cigarettes during your life? Y N
    a. Do you still smoke cigarettes? Y N
    b. If yes, how much (number of cigarettes per day): _____
    c. Are you interested in quitting? Y N
    d. Do you use any other forms of tobacco (cigars/chew)? Y N
9. Do you drink alcohol? Y N
    a. Do you or others around you feel it is a problem? Y N
10. Do you suffer from incontinence/bladder control problems? Y N
11. Do you take a daily aspirin? Y N
12. Do you have a Living Will or Power of Attorney? Y N
    a. Who should make decisions for your health if you cannot: _____
    _____

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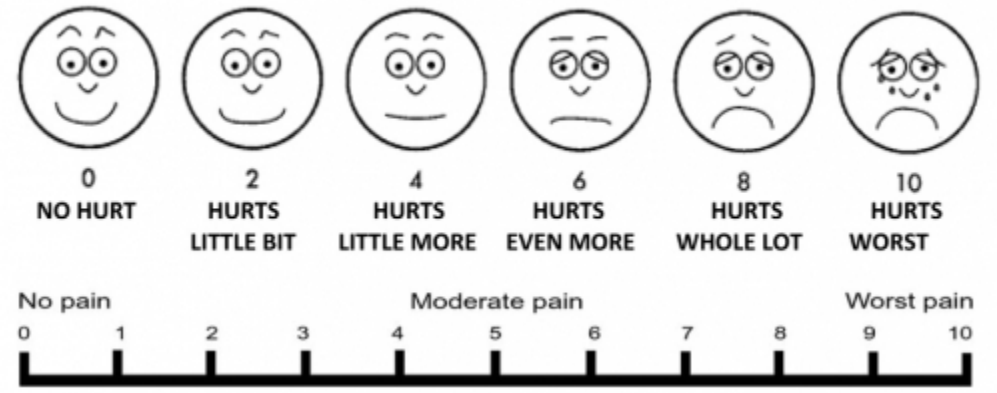
13. Do you suffer from chronic daily pain? Y N
    a. If yes, please rate your pain on the scale below:



    b. Where is your pain?: _____

14. Do you regularly exercise? Y N
    a. How many days per week? 1 2 3 4 5 6 7
    b. How long per session? (circle one) 30 mins 30-60 mins over 60 mins
    c. What exercise do you do?: _____

15. Over the past 2 weeks:
    a. Have you felt down, depressed, or helpless? Y N
    b. Have you had decreased interest/pleasure in normal activities? Y N

16. Have you had the following immunizations?
    a. Influenza Y N Year: 15 16 17 18
    b. Pneumovax 23 Y N Date: _____
    c. Prevnar 13 Y N Date: _____
    d. Zostavax Y N Date: _____
    e. Tetanus Y N Date: _____
    f. Hepatitis B Y N Date: _____

17. Have you had the following screening tests for:
    a. Colon cancer Y N
       Test: Colonoscopy Flex Sig Cologuard Stool for blood
    b. Mammogram Y N Date: _____
    c. Bone Density Y N Date: _____

Patient Health Questionnaire – PHQ-9

Patient name: _____ Date:_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	❒	❒	❒	❒
b. Feeling down, depressed, or hopeless.	❒	❒	❒	❒
c. Trouble falling/staying asleep, sleeping too much.	❒	❒	❒	❒
d. Feeling tired or having little energy.	❒	❒	❒	❒
e. Poor appetite or overeating.	❒	❒	❒	❒
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	❒	❒	❒	❒
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	❒	❒	❒	❒
h. 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 more than usual.	❒	❒	❒	❒
i. Thoughts that you would be better off dead or of hurting yourself in some way.	❒	❒	❒	❒

2. If you checked off any problem on this questionnaire so far, how difficult 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

TOTAL SCORE _____

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Patient's Name: _____ DOB: _____

You are on our schedule for a ***WELL EXAM*** today. If you discuss other medical concerns you may incur additional charges, which your insurance plan may determine is your responsibility. Consequently, you may have to pay a co-pay or deductible/co-insurance for the additional services rendered on the same day as your well exam.

Do you have other medical concerns that you would like to make the provider aware of?
Please note: There may not be sufficient time to perform a Well Exam and address other concerns within a single visit*

1._____

2._____

3._____

Which prescriptions do you need refilled today?
Due to the complexity of some conditions, ***not all prescription refills may be addressed today.***

Name of Medication to be REFILLED	Pharmacy (Name and cross streets)

****Speak with the Medical Assistant to prioritize your needs today****

Signature:_____ Date:_____