Village Family Medicine
A CIRCLE HEALTH MEMBER
Complete connected care℠

MEDICARE WELLNESS CHECKUP

Name: _____ **DOB:** _____Date form completed: _____

Please bring this form to your appointment scheduled with _____on _____at ___am/pm

Please complete this checklist before seeing your provider. Your responses will help you receive the best healthcare possible.

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

   ☐ Never ☐ Sometimes ☐ Often

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

   ☐ Never ☐ Sometimes ☐ Often

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

   ☐ No pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain

4. During the **past four weeks**, was someone available to help you if you needed and wanted help?

   ☐ Never ☐ Sometimes ☐ Often

5. During the **past four weeks**, what was the highest level of physical activity you could do for at least two minutes?

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

6. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis or drive your own car?

   ☐ Yes ☐ No

7. Can you go shopping for groceries or clothes without someone's help?

   ☐ Yes ☐ No

8. Can you prepare your own meals?

   ☐ Yes ☐ No

9. On a typical day, which foods do you eat?

   ☐ Fruits and Vegetables
   ☐ High fiber/whole grain foods (whole grain bread, cereal or oatmeal)
   ☐ Lean protein (grilled chicken, fish)
   ☐ High-fat foods (fried chicken, bacon, French fries, potato chips, cheese, or mayonnaise)

10. Can you do your housework without help?

    ☐ Yes ☐ No

11. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

    ☐ Yes ☐ No

12. Can you handle your own money without help?

    ☐ Yes ☐ No

13. During the **past four weeks**, how would you rate your health in general?

    ☐ Excellent ☐ Good ☐ Fair ☐ Poor

14. How have things been going for you during the **past four weeks**?

    ☐ Very well; could hardly be better
    ☐ Pretty well
    ☐ Good and bad parts, about equal
    ☐ Pretty bad
    ☐ Very bad; could hardly be worse

15. Are you having difficulty driving your car?

    ☐ Yes, often
    ☐ Sometimes
    ☐ No
    ☐ Not applicable, I do not use a car

16. Do you always fasten your seat belt when you are in a car?

    ☐ Yes, usually ☐ Yes, sometimes ☐ No

17. Have you fallen two or more times in the **past year**?

    ☐ Yes ☐ No

18. Are you afraid of falling?

    ☐ Yes ☐ No

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19. How often during the past four weeks have you been bothered with any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up					
Sexual problems					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					
Problems hearing					
Problems seeing					
Tiredness or fatigue					

20. Do you smoke or use smokeless tobacco?

    ☐ No
    ☐ Yes and I might quit
    ☐ Yes, but I'm not ready to quit

21. During the **past four weeks**, how many drinks of wine, beer or other alcoholic beverages did you have?

    ☐ 10 or more drinks per week
    ☐ 6-9 drinks per week
    ☐ 2-5 drinks per week
    ☐ One drink or less per week
    ☐ No alcohol at all

22. Do you exercise for about 20 minutes three or more days a week?

    ☐ Yes, most of the time
    ☐ Yes, some of the time
    ☐ No I usually do not exercise much

23. Have you been given any information to help you with hazards in your house that might hurt you?

    ☐ Yes ☐ No

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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 established any advanced Health Care Planning (if yes, please bring a copy with you to your visit)?

    ☐ Living Well
    ☐ Durable Power of Attorney
    ☐ Advanced Directives
    ☐ Other

26. 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

27. Have you been given any information to help you keep track of your medications?

    ☐ Yes ☐ No

28. If you take any medications (prescription or over the counter), vitamins, calcium or supplements, please list them below:

Name	Dosage	Frequency