Patient Name ______________________________ DOB ____________________

Medicare Wellness (please circle the correct response)

1. In the last 30 days have you used tobacco?

Smoke daily   Smoke some days   Former smoker   Never Smoker

2. If Yes, would you be interested in quitting tobacco use within the next month?

Does not Apply   Yes   Has tried unsuccessfully before

Interested in quitting at a later date   Has Never tried to quit

3. In the last 7 days, how often did you have four or more alcoholic drinks at one time?

Never   Once   2-3 times   More than 3 times

4. Do you ever drive after drinking, or ride with a driver who has been drinking?

Yes   No

5. In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day?

Every day   3-6 days   1-2 days   0 days

6. How many days a week do you exercise on average?

0   1   2   3   4   5   6   7

7. On days when you exercised, how long did you exercise for?

N/A   5-10 minutes   10-15 minutes   15-20 minutes   20-30 minutes

30-45 minutes   45-60 minutes   More than an hour

8. How intense was your typical exercise?

Light (like stretching or slow walking)

Moderate (like brisk walking)

Heavy (like jogging or swimming)

Very heavy (like fast running or stair climbing)

I am not currently exercising

9. Each night, how many hours of sleep do you usually get?

Less than 4   4-5   5-6   7-8   9-10   More than 10 hours

10. Do you snore or has anyone told you that you snore?

Yes   No

11. In the past 7 days, how often have you felt sleepy during the daytime?

Always   Sometimes   Usually   Rarely   Never

Patient Name ______________________________ DOB ____________________

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

Yes No

13. Do you live with someone else?

No Spouse Relatives Caregiver Group Home Partner Parents Hospice

14. Does your home have grab bars in the bathroom?

Yes No

15. Does your home have handrails on the stairs?

Yes No

16. Are you currently taking any medications (prescribed or over the counter)? (If yes, please use list attached)

Yes No

17. Are you taking any vitamins or other supplements? (If yes, please use list attached)

Yes No

18. Are you allergic to any medications?

Yes No

19. Are you allergic to any foods or other substances?

Yes No

20. Does any family member have history of alcoholism, cancer, high cholesterol, seizures, anemia, sickle cell, diabetes, hypertension, stroke, arthritis, heart disease, obesity, thyroid disease, bleeding disorders, liver disease, kidney disease, myocardial infarction, etc.? (Grandparents, Parents, Siblings)

Yes No

21. Have you undergone any surgeries in the past? (Major Surgeries)

Yes No

22. What race do you identify with? (please write answer below)

23. What is your ethnicity? (please write answer below)

24. What is your marital status?

Single Married Separated Divorced Widowed

Patient Name ________________________________ DOB ____________________

25. Do you have a Medical Power of Attorney? (someone to make medical decisions for you in the event you are unable to)

Yes No Don't know/Don't remember

26. Do you have a living will or advance directive?

Yes No

27. Is a copy of your advance directive on file at your doctor's office?

Yes No Don't know/don't remember

28. In general, how would you describe your health?

Excellent Good Very Good Fair Poor

29. How would you describe the condition of your mouth and teeth- including false teeth or dentures?

Excellent Good Very Good Fair Poor

30. Do you currently have hearing problems or have you in the past?

Yes No

31. During the past year, have you experienced changes in thinking, remembering, or decision-making? For example, have you had more difficulty remembering people, places, or things? Have you had more difficulty making decisions?

Yes No

32. Do you or any of your friends or family members have any concerns about your memory?

Yes No

33. In the past 2 weeks, how often have you felt down, depressed, or hopeless?

Almost all of the time Most of the time Some of the time Almost never

34. In the past 2 weeks, how often have you felt little interest or pleasure in doing things?

Almost all of the time Most of the time Some of the time Almost never

35. Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?

Yes No

36. In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

Almost all of the time Most of the time Some of the time Almost never

37. In the past 2 weeks, how often were you not able to stop worrying or control your worrying?

Almost all of the time Most of the time Some of the time Almost never

Patient Name ________________________________ DOB ____________________

38. How often is stress a problem for you in handling such things as your health, your finances, your family or social relationships, or your work?

Always Often Sometimes Rarely Never

39. In the past 7 days, how much pain have you felt on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

40. Is there a known reason for your pain?

Yes No

41. How often do you get the social and emotional support you need?

Always Often Sometimes Rarely Never

42. Screening schedule:

	Performed (Date)	Scheduled (Date)
Cardiovascular Screening/Counseling		
Diabetes Screening/Counseling		
Colorectal Cancer Screening/Counseling		
Lung Cancer Screening/Counseling		
Osteoporosis Screening/Counseling		
Abdominal Aortic Aneurysm Screening/Counseling		
Glaucoma Screening/Counseling		
HIV Screening/Counseling		
Smoking Cessation Counseling		

43. Screening schedule (females only):

Breast Cancer Screening/Counseling		
Cervical Cancer Screening/Counseling		

44. Screening schedule (males only):

PSA Screening/Counseling		