MEDICARE WELLNESS

PATIENT NAME:_____ DATE OF BIRTH: _____

Is this your first 12 months of Medicare? YES NO

In general, how would you rate your overall health?

Excellent	Very Good	Good	Fair	Poor	Stable

In general, how would you rate your overall emotional/mental health?

Excellent	Very Good	Good	Fair	Poor

Do you have trouble hearing?

NO	Yes, but it doesn't bother me or others	Yes, and it is an issue for me and/or others

Do you need assistance with any of the following?

Grooming	Housekeeping	Getting dressed	Shopping
Bathing	Preparing meals	Using the toilet	Using the phone
Eating	Managing money	Doing laundry	

Do you have cognitive impairments?

NO	Difficulty with checkbook	Difficulty expressing self
Being treated for dementia	Difficulty planning/cooking meals	Difficulty following conversations
Repeats recent conversations	Trouble driving	Forgets appointments
Repeats or asks questions	Gets lost outside of home	

Because of physical/mental conditions, do you have difficulty concentrating, remembering or making decisions?

YES	NO

Do you have excessive worry or stress in your life?

Where do you live?

YES	NO

Apartment	Senior living facility	Nursing home	House	Assisted living	Trailer

Do you feel safe at home?

YES	NO

Who would help you if you became ill or injured?

Caregiver	Friend	None	Spouse	Children	Neighbors	Other family

Do you have smoke and carbon monoxide detectors? YES NO

Do you have safety bars in the bathroom? YES NO

Do you ever take your medications for reasons other than what they are prescribed for? YES NO Would

your family feel safe riding in a car if you were driving? YES NO

How many times have you fallen in the past year and were you injured?

No falls in the past year	2 or more falls in the past year, but no injury
1 fall in the past year, but no injury	2 or more falls in the past year, and injured
1 fall in the past year and injured	I do not walk

Do you use a cane or walker consistently? YES NO

1. Are you generally able to eat well? YES NO 2. Have you lost or gained weight without trying in the past year? YES NO 3. Do you eat plenty of vegetables, fruits, whole grains, and lean proteins? YES NO 4. Do you feel that you eat too much sugar and/or unhealthy fats? YES NO 5. Do you participate in activities to increase your heart rate several days per week? YES NO 6. Do you participate in strength building activities at least twice per week? YES NO

Do you smoke? YES NO

Do you use illegal street drugs? YES NO

MEN:
Do you consume more than 2 servings of alcohol a day? YES NO

WOMEN:

Do you consume more than 1 serving of alcohol a day? YES NO

In the event of terminal illness, would you prefer aggressive treatment or comfort care only?

Aggressive	Comfort

In the event of irreversible brain death, would you prefer aggressive treatment or comfort care only?

Aggressive	Comfort

Do you have advanced directive documents?

NO	Living will	Medical power of attorney	Out of hospital DNR	Scope of treatment

Please list all specialist/doctors that you receive care from?

Provider Name	Specialty	Phone/Address