MEDICARE WELLNESS PRE-VISIT FORM

Patient Name:_____ DOB:_____

1) In general, would you say your health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2) How confident are you that you can control and manage most of your health problems/issues?

☐ Very Confident ☐ Somewhat confident ☐ Not very confident
☐ I don't have any health problems

3) What is your housing situation today?

☐ I do not have housing ☐ I have housing, but am worried about losing it

☐ I have housing

4) Think about the place you live. Do you have problems with any of the following?

☐ Bug infestation ☐ Mold ☐ Lead paint or pipes ☐ Inadequate heat
☐ Oven or stove not working ☐ No or not working smoke detectors
☐ Water leaks ☐ None of the above

5) Home safety checklist

Are there smoke detectors in your living area? ☐Yes ☐No

Is a carbon monoxide detector installed? ☐Yes ☐No

Do you use a seatbelt? ☐Yes ☐No

Does your home have grab bars in the bathroom? ☐Yes ☐No

Do you have throw rugs on the floor? ☐Yes ☐No

Do you have firearms in your home? ☐ Yes ☐ No

If yes, are they locked? ☐ Yes ☐ No

6) Do you have trouble remembering or recalling facts or events? ☐Yes ☐No

7) Do family members or caregivers report that you have difficulty remembering things? ☐Yes ☐No

8) During the past 4 weeks, how much bodily pains have you generally had?

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

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ADL's

9) In the past 4 weeks did you need help from others to perform any of these everyday activities?

☐ Bathing ☐ Dressing ☐ Grooming ☐ Eating
☐ Walking ☐ Using the toilet ☐None

10) In the past 4 weeks did you need help from others to take of any of these chores?

☐ Laundry ☐ Housekeeping ☐ Preparing a meal ☐ Shopping
☐ Transportation ☐ Managing finances ☐ Managing own medications
☐ Using the telephone ☐None

11) Are you having difficulties driving your car?

☐ Yes, often ☐ Sometimes ☐ No ☐ NA- I don't use a car

12) In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

☐ Yes, it has kept me from medical appointments or getting medications
☐ Yes, it has kept me from nonmedical meetings, appointments, work, or getting things I need ☐ No

13) Have you fallen two or more times in the past year? ☐Yes ☐No

14) Are you afraid of falling? Do you feel unsteady? ☐Yes ☐No

15) During the past 4 weeks how much have you been bothered by feelings of stress, anger, loneliness?

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

16) During the past 4 weeks, has your physical or emotional health limited your social activities with family and friends?

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

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17) Personal Safety

How often does anyone physically hurt you?	Never	Rarely	Sometimes	Fairly Often	Frequently
How often does anyone insult or talk down to you?	Never	Rarely	Sometimes	Fairly Often	Frequently
How often does anyone threaten you with harm?	Never	Rarely	Sometimes	Fairly Often	Frequently
How often does anyone scream or curse at you?	Never	Rarely	Sometimes	Fairly Often	Frequently

18) Are you a smoker/tobacco user?

☐No-never ☐No-former ☐Yes, and I am interested in quitting ☐Yes, but I'm not ready to quit

19) In the past 12 months, how often have you had more than 4 drinks containing alcohol?

☐Never ☐Once during the week ☐2-3 times/week ☐>3 times/week

20) In the past 12 months, have you had difficulties with food or utility affordability?

☐Yes ☐ No ☐ I get assistance with these ☐ I need help getting assistance

21) What specialist(s) do you actively see? And when was your last visit?

_____

_____

22) Did you receive a new diagnosis or medication? If so, please list here _____

MEDICARE WELLNESS PRE-VISIT FORM

Patient Name:_____ DOB:_____

_____

23) Where do you get your vision screens done? _____
When was your last one?_____

24) Where do you have your hearing checked?_____

When was this last done?_____

PHQ- 9

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

	Not at all	Several days	More than half the days	Nearly everyday
Little interested or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people 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
Thoughts that you would be better off dead, or hurting yourself	0	1	2	3
If you checked off any problems, 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:_____

Would you like assistance with anything on this form?_____

_____

_____

_____