Medicare Wellness Questionnaire

Patient Details – Filled out by Clinic

First Name		**Last Name**	
Medicare/SSN		**DOB**	
Gender		**MRN**	
		PCP	

Vitals – Filled out by Clinic

Weight		Height		B/P	

Gender	Female	Male

What is your race?	White/Caucasian	Black/African American	Hispanic, Latino
Asian	Native Hawaiian/Pacific Islander	American Indian/Alaskan Native	Other

What is your marital status?			
Widowed	Divorced	Single	Married/Partnership

Who else lives in your home with you?				
I live in a care facility	Paid care-giver	Roommate	Spouse/family	I live alone

How would you rate your overall health?				
Excellent	Good	Average	Poor	Very Poor

Do you feel confident you can manage most of your health problems?	
Very confident	Somewhat confident
Not very confident	I cannot manage my health on my own

Do you have any of these problems? (Circle all that apply)		
Transportation to/from appointments	Cost of care or medications	
Understanding Health info	Family issues or lack of help	None

Have you been to an Emergency Room in the last 6 months?	Yes	No

Have you stayed overnight in a hospital in the past 12 months?	Yes	No

Has anyone in your family ever had any of these conditions? (Circle all that apply)				
Alcohol Abuse	Allergies	Alzheimers or Dementia	Anemia	Arthritis
Asthma	Autoimmune Disorder	Bleeding Disorder	Cancer, Breast	Cancer, Colon
Melanoma	Cancer, Ovary	Cancer, any other	Colon Polyps	Depression
Diabetes	Glaucoma	Heart Disease	Heart Attack	High Blood Press
High Cholesterol	Immune Disorder	Kidney Disease	Liver Disease	Lung Disease
COPD	Mental Health Disorder	Osteoporosis	Stroke	Substance Abuse
Tuberculosis	Other	None		

How many times have you seen a doctor in the last 12 months?				
1-3 visits	4-6 visits	7-10 visits	More than 10 visits	None

Which of the following have you seen in the last 2 years? (Circle all that apply)				
Primary Care	Cardiologist	Dentist	Dermatologist	Endocrinologist
ENT Specialist	Gynecologist	Immunologist	Internal Medicine	Neurologist
Oncologist	Orthopedic Surgeon	Psychologist	Pulmonologist	Rheumatologist
Urologist	Other	None		

Do you make your own meals?		
Yes	I sometimes need help	No, I always need help

How many full meals do you usually eat each day?	4 or more	3	2	1	0

How many servings of fruit or vegetables do you eat each day?	3 or more	2	1	0

How many servings of meat or fish or eggs do you each day?	3 or more	2	1	0

Do you smoke cigarettes or use tobacco?	No	I smoke cigarettes
I smoke cigars/pipe	I use chewing tobacco	I used to smoke in the past, but quit

How many cigarettes do you smoke per day?		Less than 5
More than 5, but less than a pack	One pack per day	More than 1 pack per day

Do you use any of the following? (Select all that apply)	
Sleeping pills or sedatives	Marijuana
Stimulants	Oxycodone, Oxycontin, or Vicodin
Cocaine, Heroin, or Ecstasy	None

How often do you drink alcohol?	Never	Once a month or less	One a week or less
2-3 times a week	4 or more times a week	I quit drinking	

How many alcoholic drinks do you have when you are drinking?				
None	1 or 2	3 or 4	5 or 6	7 or more

Have you been sexually active in the past year? (OPTIONAL)	Yes	No

Have you been tested for Sexually Transmitted Diseases (STD's) and/or HIV?			
Yes, STD's	Yes, HIV	Yes, for both STD's and HIV	No

Which of the following medications do you take?			
Acid Reflux/Heartburn Medication		Allergy Medication	
Anti-Anxiety Medication		Anti- Seizure Medication	
Antibiotics/Anti-Infective		Aspirin (daily)	
Asthma Medication/Inhaler		Blood Pressure Medication	
Blood Thinner		Cancer Medication (oral)	
Cancer Treatment (radiation/chemo)		Cholesterol Medication	
COPD or Emphysema Medication		Dementia Medication	
Depression Medication		Diabetes Medication (oral)	
Diabetes Medication/Injections/Insulin		Glaucoma Medication	
Heart Failure Medication		Heart Rhythm Medication	
Lung/Respiratory Medication/Inhaler		Osteoporosis Medication	
Oxygen Therapy		Pain Medication	
Sleep Medication		Steroids/Prednisone	
Tobacco Cessation Medication		Thyroid Medication	
Water Pill/Diuretics		None of these	
Other			

Do you have any of these problems taking medications? (Circle all that apply)		
Swallowing Pills	Paying for Prescriptions	Using my inhaler (s)
Giving myself injections	Remembering to take them	None of these

When was your last flu shot?	This year (this season)	Last year (last season)
I don't remember	Never	

When was your last Pneumonia Vaccine?	After age 65, I had one or more Pneumonia shots	
I'am younger than 65, I've had at least one shot	I've had one Pneumonia shot	I don't remember
I've never had a Pneumonia shot		

Have you had a Shingles Vaccine?	Yes, the new one, Shingrix	Yes, but only Zostovax
Yes, but don't know which one	No	I don't know

When was your last mammogram?	I am a Male, I have had a mammogram
I am Male, no mammogram has been needed	I am Female, within the last 2 years
I am Female, within more than 2 years ago	I am Female, never had a mammogram

Have you been tested for Osteoporosis?	Yes	No	I don't know

When was your last colonoscopy?	I've had a stool test at least every 2 years
I had a sigmoidoscopy within the last 4 years	I had a colonoscopy within the last 10 years
I'm not sure or I'm past due	I've never had a Colon Cancer screening

Have you ever been told your Cholesterol level was high?	Yes	No	I don't remember

Have you ever been told you have any of the following conditions?		Diabetes or High Blood Sugar
Alzheimer's or Dementia	Heart Disease or Heart Attack	COPD/Emphysema
Depression	Stroke	None

You checked Diabetic or high blood sugar. Are you:		
Diabetic taking insulin	Diabetic NOT taking insulin	Not Diabetic, but have high blood sugar

Do you have bladder control problems (leak urine)?				
Never	Rarely	Sometimes	Often	Every Day

When was your last PSA screening for Prostate Cancer	I am Female, does not apply	
Within the last year	More than 1 year ago	I have never had a PSA test

During the past four weeks, how much pain have you had?				
No pain	Very mild pain	Mild pain	Moderate pain	Severe pain

Select 3 words from the list to remember later.						
Checkers	Saucer	Telegram	Red Cross	Brooch	Theater	Racing

Checkers falls into which following category?				
Trees	Buildings	Games	Shapes	Animals

Which option is WORLD spelled backwards?				
WORLD	DLRWO	DLROW	DRLOW	LDRWO

How well are you able to manage your daily activities?			
Very well	Somewhat well	Not very well	Not at all

Please select the same 3 words from the list that you selected previously.						
Red Cross	Telegram	Checkers	Racing	Saucer	Theater	Brooch

Can you get to places beyond walking distance without help?	Yes	Sometimes	No

Can you go shopping without help?	Yes	Sometimes	No

Can you do housework without help?	Yes	Sometimes	No

Do you need help eating, dressing, bathing or getting around the house?		
Yes	Sometimes	No

Can you manage your money (banking and bills) without help?	Yes	No

Have you been experiencing any of the following:	
Dizziness standing up/getting out of bed	Difficulty chewing or swallowing
Difficulty breathing or shortness of breath	Snoring or choking/gasping during sleep
Confusion or forgetfulness	None of these

Which of the following are NOT in your home?		
Safety bars in bathroom	Smoke detectors	Anti-slip rugs
Sturdy railings on stairs	Automatic lights	None of these

Have you fallen in the past year?	Yes		No
If yes, how many times did you fall?	1	2	3 or more

How often do you fee shaky when standing or walking?			
Never	Sometimes	Often	Always

Do you exercise for 20 minutes 3 or more days a week?			
Always	Most weeks	Sometimes	Never

Do you need to take a nap during the day?			
Never	Once or twice a week	Every other day	Every day

Do you have trouble hearing?	Yes	No	Sometimes

Do you have trouble seeing?	Yes	No	Sometimes

When was your last eye exam?	This year (within the past 12 months)
Last year (more than 12 months ago)	More than 2 years ago

When was your last dental exam?	This year (within the past 12 months)
Last year (more than 12 months ago)	More than 2 years ago

In the last month, have your health or emotions stopped you from being with Family or Friends?				
Never	A few times	Sometimes	Many times	All of the time

Do you have someone to assist you when you need help?			
Always	Most of the time	Sometimes	Never

How often do you get social and emotional support you need?				
Always	Usually	Sometimes	Rarely	Never

How often do you speak with family or friends?				
Every day	A few times a week	Every few weeks	A few times a year	Never

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

Having little interest or pleasure in doing things			
Nearly every day	More than half the days	Several days	Not at all
Feeling down, depressed, or helpless			
Nearly every day	More than half the days	Several days	Not at all
Trouble falling asleep, staying asleep, or sleeping too much			
Nearly every day	More than half the days	Several days	Not at all
Feeling tired or having little energy			
Nearly every day	More than half the days	Several days	Not at all
Poor appetite or overeating			
Nearly every day	More than half the days	Several days	Not at all
Feeling bad about yourself – or that you are a failure or have let yourself or your family down			
Nearly every day	More than half the days	Several days	Not at all
Trouble concentrating on things, such as reading the newspaper or watching television			
Nearly every day	More than half the days	Several days	Not at all
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 a lot more than usual			
Nearly every day	More than half the days	Several days	Not at all
Thoughts that you would be better off dead or of hurting yourself in some way			
Nearly every day	More than half the days	Several days	Not at all

How difficult have these problems made it for you to do work, take care of things at home, or get along with people			
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Would you like to talk to your doctor about Advanced Directives?		
Living Will	Power of Attorney (POA)	Do not Resuscitate (DNR)
All of the above	None	

As a Medicare beneficiary, you may be eligible to receive additional support from your healthcare team. Would you be interested in learning more about our Medicare-sponsored care coordination program?		
Yes, I'd like to learn more	No, I'm not interested	I'm not sure or I don't know