# MEDICARE WELLNESS CHECKUP

Your name:___________________

Todays date:___________________

Birthdate:___________________

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

- ☐ What is your age?
- ☐ 65-69
- ☐ 70-79
- ☐ 80 or older

2. ☐ Male
   ☐ Female

3. 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?

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

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

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

5. During the past four weeks, how much bodily pain have your generally had?

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

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

   (For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores, or needed help just taking care of yourself)

   - ☐ Yes, as much as I wanted
   - ☐ Yes, quite a bit
   - ☐ Yes, some
   - ☐ Yes, a little
   - ☐ No, not at all

7. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?

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

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

   ☐Yes ☐No

9. Can you go shopping for groceries or clothes without someones help?

   ☐Yes ☐No

10. Can you prepare your own meals?

    ☐Yes ☐No

11. Can you do your housework without help?

    ☐Yes ☐No

12. 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

13. Can you handle your own money?

    ☐Yes ☐No

14. During the past four weeks, how would rate your health in general?

    ☐Excellent ☐Very Good ☐Good
    ☐Fair ☐Poor

PATIENT NAME______________________________ DATE____________________

15. How have things been going for your during the past four weeks?

☐Very well; could hardly be better
☐ Pretty well ☐Good and bad parts equal
☐ Pretty bad ☐Very bad; couldn't be worse

16. Are you having difficulties driving a car?

☐Yes, often ☐Sometimes
☐ No ☐Not applicable/don't drive

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

☐Yes, usually ☐Yes, sometimes
☐No

18. How often during the past four weeks have you been bothered by 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 | | | | | |
| Tiredness or fatigue | | | | | |

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

☐Yes ☐No

20. Are you afraid of falling?

☐Yes ☐No

21. Are you a smoker?

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

22. 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 a week ☐ 2-5 drinks per week
☐ One drink or less per week ☐ No alcohol at all

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

☐Yes, most of the time ☐Yes, sometimes
☐No, I usually don't exercise this much

24. Have you been given any information to help you with the following?

Hazards in your house that may hurt you?

☐Yes ☐No

Keeping track of medications?

☐ Yes ☐ No

25. How often do you have trouble taking medications the way you have been told to take them?

☐ I do not have to take medication
☐ I always take them as prescribed
☐ Sometimes I take them as prescribed
☐ I seldom take them as prescribed

26. 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 health problems

27. What is your race? (check all that apply)

☐ White ☐Black/African American
☐ Asian ☐Native Hawaiian or Pacific Islander
☐ American Indian or Alaskan Native
☐ Hispanic or Latino origin or descent
☐ Other

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Name ______________________________ DOB ______________ Date____________

# CARDIOVASCULAR RISK SCREENING TOOL (CRST)

Heart attacks and strokes cause more deaths than anything else. While we all will "go sometime," there's plenty of reason to try to postpone or avoid these problems. Here's a checklist of conditions that can contribute to having a heart attack (Myocardial Infarction or "MI") or stroke (Cardio Vascular Accident or "CVA"). Please circle your answers. Thank you.

| MAJOR RISK FACTORS (2 points): | YES | NO |
|---|---|---|
| 1. Smoking cigarettes | YES | NO |
| 2. Diabetes | YES | NO |
| 3. Cholesterol (high LDL or low HDL or both) | YES | NO |
| 4. High Blood pressure | YES | NO |
| 5. Blood relatives with MI or CVA before age 65 | YES | NO |
| 6. Prior MI or CVA | YES | NO |
| 7. Prior use of cocaine, meth or other stimulants | YES | NO |
| 8. Sedentary (less than 1 hour exercise weekly) | YES | NO |
| 9. Stress (especially "suffer in silence") | YES | NO |
| 10. Overweight | YES | NO |
| 11. Sleep Apnea | YES | NO |

| LESSER RISK FACTORS (1 point): | YES | NO |
|---|---|---|
| 12. Electromagnetic fields (work in big factories) | YES | NO |
| 13. Prolonged NSAID use (e.g. Ibuprofen/Aleve) | YES | NO |
| 14. Gout (or high uric acid level) | YES | NO |

**TOTAL POINTS:** ____

**RISK FACTORS YOU CAN'T CORRECT:**

Family Tendency  Prior Event  Prior Use of Stimulants  Factory/Power line work  Long term NSAID

**OTHER RISK FACTORS CAN BE CORRECTED:**

Stop Smoking  Start Exercising  Lose Weight  Get BP down (diet/meds)  Reduce uric acid (med)

Correct cholesterol with Statin  Learn to manage stress  Normalize blood sugars

**IF you wish, we can arrange a visit to discuss your risk factors and make specific plans to fix them.**

Revised 6/27/17

## END OF LIFE DISCUSSION

NAME ______________________________ D.O.B. ____________ DATE ____________

**Medicare wants to make sure that you get the care you want if you can't speak for yourself due to injury or illness. Therefore they want us to think about these "end of life" issues. Your answers below are NOT A LEGAL DOCUMENT, but will help us to provide the care you want. Please circle your answers:**

1. DO you have an Advanced Directive in place?

   YES NO

2. If something happens to you and you can't make your wishes known, do you have a "Power of Attorney"? (most people do not)

   YES NO If yes, who is that person? ______________________________

3. IF your heart stopped right now, would you want us to try to revive you?

   YES NO, just let me go

4. ~~IF you are suddenly put on a respirator (such as if you're unconscious and not breathing, with a~~ car accident), would you want to remain on the respirator?

   YES, temporarily NO, take me off immediately

5. IF you are on the respirator, how long would you want to be on this life support?

   A FEW DAYS? A FEW WEEKS? A FEW MONTHS? NONE—TAKE ME OFF NOW

6. IF you are in a coma and NOT on life support, would you want IV fluids?

   YES NO

7. IF you are in a coma and NOT on life support, would you want feedings by IV or tube?

   YES NO

8. IF you are in a coma and NOT on life support, would you want antibiotics if you got infected?

   YES NO

**If you would like a form to take home and fill out please let us know. Given: Yes _____ No _____**

NAME: ______________________________ DATE: ________________________

## AUDIT-C

**How often** do you drink any alcohol ever: Never? (0), Monthly or less? (1), 2-4 times per month? (2), 2-3 times per week? (3), 4 or more times per week (4)

**How many** drinks do you have on a typical day if you are drinking? 1-2 (0), 3-4 (1), 5-6 (2), 7-9 (3), 10 or more (4)

**How often** did you have six or more drinks on one occasion in the past year? Never (0), less than monthly (1), Monthly (2), Weekly (3), Daily or almost daily (4)

**TOTAL** _____

## PHQ-9 Questionnaire for Depression

**Over the past 2 weeks**, how often have you been bothered by any of the following problems? Write in number to indicate answer: Never (0) Occasionally (1) More than half the days (2) Nearly Daily (3)

1. Little interest in doing things: _____
2. Feeling down, depressed, or hopeless: _____
3. Trouble falling or staying asleep, or sleeping too much: _____
4. Feeling tired or having little energy: _____
5. Poor appetite or overeating: _____
6. Feeling bad about yourself/ that you are a failure/ or have let yourself or your family down: _____
7. Trouble concentrating on things, such as reading the newspaper or watching television: _____
8. 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: _____
9. Thoughts that you would be better off dead, or of hurting yourself: _____

**TOTAL:** _____

*Healthcare Professional: For interpretation of Totals, please refer to accompanying score card