MEDICARE WELLNESS CHECK-UP

Name_____ DOB:_____Date:_____

HEALTH RISK ASSESSMENT

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

Age_____ Are you male or female _____

Are there other physicians/specialist you follow with on a regular basis? yes no

If so please list them here: (please include eye doctor, dermatologist and gynecologist if you follow regularly with those physicians).____
_____
_____
_____
_____

Are you a smoker?

___No

___Yes and I might quit

___Yes but I am not ready to quit

If you are a current or former smoker:

What age did you start smoking? _____

On average how may packs a day did you or do you smoke? _____

If you are a former smoker, what age did you quit? _____

Over the last 2 weeks have you felt little interest or pleasure in doing things? yes no

Over the last 2 weeks have you felt down, depressed or hopeless? yes no

Did you have a drink with alcohol in it in the last year? yes no

During the past 4 weeks, how much bodily pain have you generally had?

__ No pain

__ Very mild pain

__ Mild pain

__ Moderate pain

__ Severe pain

Have you fallen within the last 12 months? yes no

Are you afraid of falling? yes no

Do you feel dizzy when standing up?

__ Never

__ Seldom

__ Sometimes

__ Often

__ Always

Do you use equipment to help you walk or get around? yes no

If so what type of equipment do you use? _____

Have you seen an eye doctor in the last year? yes no

Do you have trouble hearing? yes no

During the past 4 weeks, was someone available to help you if you have 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

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

__ I do not take any medicine

__ I always take them as prescribed

__ Sometimes I take them as prescribed

__ I seldom take them as prescribed

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 any health problems

Do you have a living will, advance directives, or healthcare surrogate/medical power of attorney? yes no

If so, which of the above do you have? _____

Do you take any vitamins or supplements? yes no

If so,. please list them:_____

_____

_____

_____

What is your race? (mark all that apply)

__ White

__ Black/African American

__ Asian

__ Native Hawaiian/Other Pacific Islander

__ American Indian/Alaskan Native

__ Hispanic or Latino origin or descent

__ Other