Name: _____ Date: _____ Date of Birth: _____

A Checklist for Your Medicare Wellness Annual Visit

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

1. During the past 4 weeks, have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
☐ Yes ☐ No

2. During the <u>past 4 weeks</u>, has your physical and emotional health limited your social activities with family, friends, neighbors or groups?
☐ Yes ☐ No

3. Have you been bothered by any of the following problems?

	Yes	No
Fall or dizzy when standing up		
Sexual problems		
Trouble swallowing		
Teeth or dentures		
Problems using the telephone		
Tired or fatigued		
Bladder control/urination		

4. Do you have trouble hearing the television or radio when others do not?
☐ Yes ☐ No

5. Do you have to strain or struggle to hear/understand conversations?
☐ Yes ☐ No

6. Are you having difficulties driving your car?
☐ Yes ☐ No

7. Do you always fasten your seat belt when you are in a car?
☐ Yes ☐ No

8. How often do you drink alcohol?
☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily

9. When you drink, how many drinks do you consume?
☐ 1-2 ☐ 3-4 ☐ More

10. Has anyone told you that you may have a drinking problem?
☐ Yes ☐ No

11. Are you a smoker?
☐ Yes ☐ No

If you are a former smoker, when did you quit? _____
If you are or used to be a smoker,
How many packs per day do/did you smoke? _____
How many years have you been/did you smoke? ____

12. During the past 4 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 ☐ No

13. Can you get places out of walking distance without help? For Example, can you travel alone by bus, taxi or drive your own car? ☐ Yes ☐ No

14. Can you prepare your own meals? ☐ Yes ☐ No

15. Can you do your own housework without help?
☐ Yes ☐ No

16. Do you need help eating, bathing, dressing or getting around your home? ☐ Yes ☐ No

17.Can you shop for groceries or clothes without help?
☐ Yes ☐ No

18. Do you exercise for about 20 minutes 3 or more days a week?
☐ Yes ☐ No

19. Have you discussed the following information with our health care provider? :
- Hazards in your house that might hurt you?
☐ Yes ☐ No
- Keeping track of your medication?
☐ Yes ☐ No

20. Do you take medication every day as directed?
☐ Yes ☐ No

21. Can you manage your health problems?
☐ Yes ☐ No

Patient Consent: "I consent to discuss end-of-life issues with my healthcare provider."

_____/_____
Patient/Guardian Signature/ Date

(OVER)

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Has the patient already executed an advance directive?
☐ Yes ☐ No

Does this individual have the ability to prepare an advance directive? ☐ Yes ☐ No

Has provider completed an order for life-sustaining treatment or similar document reflecting the patient's wishes for an advance care plan? ☐ Yes ☐ No

Is the physician willing to follow the patient's wishes?

☐ Yes ☐ No

_____/_____
Provider's Signature/ Date