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 past 4 weeks, 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. Are you capable to 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 Revised 05/18/2017

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