## MEDICARE ANNUAL WELLNESS VISIT

Please complete this checklist and return to the front desk before seeing your Doctor. Your responses will help you receive the best care possible.

Your name: _____

Today's date: _____

Your date of birth: _____

1. During the **past 2 weeks**, how often have you been bothered by the following problems?

| | Not at all | Several Days | More than Half the Days | Nearly Every Day |
|---|---|---|---|---|
| Little interest or pleasure in doing things. | ☐ | ☐ | ☐ | ☐ |
| Feeling down, depressed, or hopeless. | ☐ | ☐ | ☐ | ☐ |

2. Have you fallen two or more times in the past year?
   ☐ Yes ☐ No
3. Are you afraid of falling?
   ☐ Yes ☐ No
4. Are you limited in any way by your ability to hear?
   ☐ Yes ☐ No
5. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have per week?

| 0 | 2-4 | 4-6 | 6-10 | 10+ |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

6. Do you have trouble taking your medicines the way you have been told to take them?
   ☐ Yes ☐ No
7. During the **past 2 weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?
   ☐ Yes ☐ No
8. During the **past 2 weeks**, how much bodily pain have you had?
   ☐ No pain
   ☐ Mild pain
   ☐ Moderate pain
   ☐ Severe pain
9. During the **past 2 weeks**, was someone available to help you if you needed and wanted help?
   ☐ Yes ☐ No
10. Can you prepare your own meals?
    ☐ Yes ☐ No
11. During the **past 2 weeks**, what was the hardest physical activity you could do for at least two minutes?
    ☐ Heavy
    ☐ Moderate
    ☐ Light
12. Can you get to places out of walking distance without help? (e.g. can you travel alone on buses or taxis, or drive your own car?)
    ☐ Yes ☐ No
13. Can you go shopping for groceries or clothes without someone's help?
    ☐ Yes ☐ No
14. Can you do your house work without help?
    ☐ Yes ☐ No
15. 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
16. Can you handle your own money without help? (e.g. pay bills, track expenses, etc.)
    ☐ Yes ☐ No
17. During the **past 2 weeks**, how would you rate your health in general?
    ☐ Excellent
    ☐ Fair
    ☐ Poor

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18. How have things been going for you during the past four weeks?
    - ☐ Excellent
    - ☐ Fair
    - ☐ Poor

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

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

21. 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 | ☐ | ☐ | ☐ | ☐ | ☐ |
| Teeth or Denture Problems | ☐ | ☐ | ☐ | ☐ | ☐ |
| Problems Using the Telephone | ☐ | ☐ | ☐ | ☐ | ☐ |
| Trouble Eating | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tiredness or Fatigue | ☐ | ☐ | ☐ | ☐ | ☐ |

22. Are you a smoker?
    - ☐ Yes ☐ No

23. Are you limited in any way by your ability to see?
    - ☐ Yes ☐ No

24. Do you exercise for about twenty minutes three or more days a week?
    - ☐ Yes ☐ No

25. Have you been given any information to help you:

    Keep track of your medications?
    - ☐ Yes ☐ No

    With hazards in the house that might hurt you?
    - ☐ Yes ☐ No

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 any health problems

27. Do you or any of your friends or family members have concerns about you having any memory changes/loss?
    - ☐ Yes ☐ No

28. In the last 6 months, have you seen any other healthcare providers outside of your primary care physician?
    - ☐ Yes ☐ No

29. Do you have a living will/advanced directive (document that makes your health care wishes known)?
    - ☐ Yes, and no updates
    - ☐ Yes and I'd like to update
    - ☐ No

Village MD CHICAGO

Patient Name: _____ DOB: _____ Date: _____

Please list below the names of all the providers and healthcare agencies regularly involved in your medical care. This includes your specialists, home health agencies, eye doctors, foot doctors, etc.

| Name of Provider | Specialty |
|---|---|
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Please list below the names of all the healthcare suppliers from who you receive medical equipment. This includes oxygen, durable medical equipment, etc.

| Name of Supplier | Equipment |
|---|---|
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| | |

Please list below the medications, supplements, vitamins you take, including over the counter drugs, vitamins, and herbal supplements.

| Medication/Supplements/Vitamins | Dose | Frequency (times per day) | Pharmacy (include location) |
|---|---|---|---|
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*Please bring all medications and over-the-counter medications with you to your office visit*

| Activities of Daily Living | For each skill area listed below, mark the statement (only one) that describes you most accurately. The word "assistance" means supervision or direction. |
|---|---|
| **Bathing** | ☐ I need help getting in or out of the tub or require total bathing<br>☐ I need help with bathing more than one part of the body<br>☐ I need help in bathing only a single part of body (such as back)<br>☐ I can bath myself completely independently |
| **Dressing** | ☐ I need help with getting dressed or need to be completely dressed<br>☐ I get clothes from the closet and can put them on without assistance (this does not include any help I require to tie my shoes) |
| **Toileting** | ☐ I need help getting on the toilet, cleaning myself, or use a bedpan<br>☐ I get on and off the toilet and clean genital area without help |
| **Transferring** | ☐ I need help moving from bed to chair that requires complete Assistance<br>☐ I move in and out of bed or chair without or with minimal assistance from a personal aide |
| **Continence** | ☐ I am partially incontinent or totally incontinent<br>☐ I exercise complete self-control over urination and defecation |
| **Feeding** | ☐ I need partial or total help with feeding<br>☐ I can get food from plate into mouth without any help |