Name_____D.O.B_____Date_____

A checklist for your Medicare Wellness Annual Visit

Please complete this checklist before seeing your doctor or nurse. Your answer will help you receive the best Health Care possible.

1. During the past 4 weeks, how would you rate your health in general?
   - □ Excellent
   - □ Very good
   - □ Good
   - □ Fair
   - □ Poor

2. How have things been going for you during the past 4 weeks?
   - □ Very well-could hardly be better
   - □ Pretty good
   - □ Good and bad parts about equal
   - □ Pretty bad
   - □ Very bad

3. During the past 4 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 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?
   - □ Not at all
   - □ Slightly
   - □ Moderately
   - □ Quite a bit
   - □ Extremely

5. During the past 4 weeks, how much bodily pain have you generally had?
   - □ No pain
   - □ Very mild pain
   - □ Mild pain
   - □ Moderate pain
   - □ Severe pain

6. Do you exercise for about 20 minutes 3 or more times a week?
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ No, I usually do not exercise this much

7. During the past 4 weeks, was someone available to help you if you needed or 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

| Answer the following questions | Yes | No |
|---|---|---|
| 8. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car? | □ | □ |
| 9. Can you shop for groceries or clothes without help? | □ | □ |
| 10. Do you need help with grooming? | □ | □ |
| 11. Can you prepare your own meals? | □ | □ |
| 12. Can you do your own housework without help? | □ | □ |
| 13. Do you need help eating, bathing, dressing, or getting around your home? | □ | □ |

14. Do you usually fasten your seatbelt when you are in a car?
   □ Yes, usually □ Yes, sometimes □ No

15. How often during the past 4 weeks have you been bothered by any of the following problems?

| Question? | Never | Seldom | Sometimes | Often | Always |
|---|---|---|---|---|---|
| 16. Sexual problems | □ | □ | □ | □ | □ |
| 17. Trouble eating well | □ | □ | □ | □ | □ |
| 18. Teeth or dentures | □ | □ | □ | □ | □ |
| 19. Problems using the telephone | □ | □ | □ | □ | □ |
| 20. Tired or fatigued | □ | □ | □ | □ | □ |

21. Are you a smoker? □ No □ Yes, and I might quit □ Yes, but I am not ready to quit

22. How often do you have trouble taking medicines the way you have been told to take them?
   - □ I do not take medicine
   - □ I always take them as prescribed
   - □ Sometimes I take them as prescribed
   - □ I seldom take them as prescribed

23. 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

24. Are you having difficulties driving your car?
- □ Yes, often
- □ Sometimes
- □ No
- □ Not applicable, I do not use a car

25. Have you fallen 2 or more times in the past year □ Yes □ No
26. Are you afraid of falling? □ Yes □ No

27. Have you been giving any information to help you with the following?
Hazards in your house that may hurt you? □ Yes □ No
Keeping track of your medications? □ Yes □ No

28. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes
- □ Very heavy
- □ Heavy
- □ Light
- □ Very light

29. How old are you? □ 65-69 □ 70-79 □ 80 or older

30. Are you a Male or Female? □ Male □ Female

31. What is your race? (Check one or more than one)
- □ White
- □ Black/African American
- □ Asian
- □ Native Hawaiian/other Pacific Islander
- □ American Indian/Alaskan Native
- □ Hispanic or Latino origin or descent
- □ Other

32. Employment Status: □ Currently Working □ Retired □ Medically Unable □ Unemployed

33. Do you have a Living Will? □ Yes □ No
34. Do you have a Surrogate Decision Maker? □ Yes □ No
35. Do you have an Actionable Medical Order? □ Yes □ No
36. Do you have an Advanced Directive? □ Yes □ No

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 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 | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |