**Metropolitan Family Care Inc. Medicare Wellness Checkup**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Your responses to the questions below will help you receive the best health care possible.

1. Do you have any problems you wish to address at your visit today? (yes) or (no)

Compared with others your age, how has your overall health been in the past 4 weeks?

(Please check one) \_\_\_Excellent \_\_\_ Very Good \_\_\_ Good \_\_\_Fair \_\_\_Poor

Would you say that you are physically more active, less active or about as active as others your age? (Please check one) \_\_\_More active \_\_\_ Less active \_\_\_ About as active

Who do you live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. We would like to know about your health and physical activities. Please answer the following questions.

Do you exercise for about 20 minutes three or more days a week?

(Please check one) \_\_\_Yes, most of the time \_\_\_Yes, some of the time \_\_\_No, or usually not.

Does your health limit your ability to do moderate activities, such as walking fast, gardening, carrying two bags of groceries at a time or pushing a vacuum cleaner? (Please check one)

\_\_\_Not at all \_\_\_ A little bit \_\_\_Moderately \_\_\_ Quite a bit \_\_\_ Totally

Does your health limit more strenuous activities, such as running or jogging, lifting weights, climbing several flights of stairs or playing sports? (Please check one)

\_\_\_ Not at all \_\_\_ A little bit \_\_\_ Moderately \_\_\_ Quite a bit \_\_\_ Totally

Do you have trouble with any of the following activities because of health problems? (check all that apply)

\_\_\_ Bathing or showering \_\_\_ Getting dressed \_\_\_ Eating \_\_\_ Sitting or getting up from a chair \_\_\_ Walking \_\_\_ Using a toilet

Are you having problems with your memory? (Please check one)

\_\_\_ Frequently \_\_\_ Sometimes \_\_\_ Rarely \_\_\_ Not at all

Has pain limited your daily activities in the past four weeks? (Please check one)

\_\_\_ Not at all \_\_\_ A little bit \_\_\_ Moderately \_\_\_ Quite a bit \_\_\_ Totally

Many people sometimes have trouble controlling when they pee. This is called urinary incontinence. Have you ever had this problem? \_\_\_yes \_\_\_no.

1. Fall Risk Assessment:

In the past four weeks have you had any problems with the following?

Falling \_\_\_yes \_\_\_ no (or) Balance \_\_\_yes \_\_\_no

 Have you fallen two or more times within the past year? \_\_\_ yes \_\_\_no

 Do you have a fear of falling? \_\_\_yes \_\_\_no

 Have you fallen within the last two months? \_\_\_yes \_\_\_no

 Do you have trouble seeing? \_\_\_yes \_\_\_no

 Do you have any of the following?

 Pets \_\_\_yes \_\_\_no Throw Rugs \_\_\_yes \_\_\_no Poor Lighting \_\_\_yes \_\_\_no

 Do you take four or more medications a day? \_\_\_yes \_\_\_no

 Do you use any of the following?

 \_\_\_cane \_\_\_walker \_\_\_wheelchair \_\_\_scooter

 How is your hearing? \_\_\_Fine \_\_\_ A little down \_\_\_poor

 Do you need help with any of the following?

 Finances \_\_\_yes \_\_\_no Transportation \_\_\_yes \_\_\_no Shopping \_\_\_yes \_\_\_no

 Housework \_\_\_yes \_\_\_no Meal Preparation \_\_\_yes \_\_\_no

1. Other health issues:

During the past four weeks, were you able to get help when you wanted or needed it? For example, if you felt lonely and needed someone to talk to, needed help with household chores or were sick and needed someone to take care of you. (Please check one)

\_\_\_ Yes, I have the help I need. \_\_\_ Yes, I can usually get the help I need

\_\_\_ Yes, I can sometimes get the help I need. \_\_\_ No, there aren’t people available to help me.

Are you interested in talking to someone about your feelings? (such as sadness, anger, loneliness, worry or any other feeling that is bothering you)? \_\_\_yes \_\_\_no

Would you like more information about exercising or eating healthy? \_\_\_yes \_\_\_no

During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have? (Please check one)

\_\_\_ 10 or more drinks per week \_\_\_ 6-9 drinks per week \_\_\_2-5 drinks per week

\_\_\_ one drink per week \_\_\_ no alcohol at all.

Do you have any financial difficulties preventing you from receiving medical care, medications or eating healthy? (Please check one)

\_\_\_yes \_\_\_no If yes which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How confident are you that you can control and manage most of your health problems on your own? ( Please check one)

\_\_\_ Very confident \_\_\_Somewhat confident \_\_\_ Not very confident \_\_\_ I dont have any health problems.