

IPPE AND MEDICARE ANNUAL WELLNESS – HEALTH QUESTIONNAIRE

Dear Patient,

Please complete this checklist before seeing a member of our clinical staff. Your answers will help your healthcare provider plan your future care.

1. What is your age?

- 65-69 70-79
 80 or older other

2. Are you a female or a male?

- Female Male

3. During the **past four 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 four 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 four weeks**, how much bodily pain have you generally had?

- No pain
 Very mild pain
 Mild pain
 Moderate pain
 Severe pain

6. During the **past four 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, as much as I wanted
 Yes, quite a bit
 Yes, some
 Yes, a little
 No, not at all

Your Name: _____

Today's Date - _____

Your Date of Birth: _____

7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

- Very heavy
 Heavy
 Moderate
 Light
 Very light

8. Can you get to places out of walking distance without help? For example can you travel along on buses, taxis or drive your own car?

- Yes. No.

9. Can you go shopping for groceries or clothes without someone's help?

- Yes. No.

10. Can you prepare your own meals?

- Yes. No.

11. Can you do your housework without help?

- Yes. No.

12. 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.

13. Can you handle your own money without help?

- Yes. No.

14. During the **past four weeks**, how would you rate your health in general?

- Excellent
 Very Good
 Good
 Fair
 Poor

15. How have things been going for you during the past four weeks?

- Very Well; could hardly be better.
 Pretty well.
 Good and bad parts about equal.
 Pretty bad.
 Very bad; could hardly be worse.

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16. Are you having difficulties driving your car?

- Yes, often.
- Sometimes.
- No.
- Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?

- Yes, usually.
- Yes, sometimes.
- No.

18. Have you fallen two or more times in the past year?

- Yes.
- No.

19. Are you afraid of falling?

- Yes.
- No.

20. Are you a smoker?

- No.
- Yes, and I might quit.
- Yes, but I'm not ready to quit.

21. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- 10 or more drinks per week.
- 6-9 drinks per week.
- 2-5 drinks per week.
- One drink or less per week.
- No alcohol at all.

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

- Yes, most of the time.
- Yes, some of the time.
- No, I usually do not exercise this much.

23. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

- Yes
- No

Keeping track of your medications?

- Yes
- No

25. How often do you have trouble taking medications the way you have been told to take them?

- I do not have to take medications.
- I always take them as prescribed.
- Sometimes I take them as prescribed.
- I seldom take them as prescribed.

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. What is your race? (Check all that apply)

- White.
- Black or African American.
- Asian.
- Native Hawaiian or Other Pacific Islander.
- American Indian or Alaskan Native.
- Hispanic or Latino origin or descent.
- Other.

28. 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					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					
Tiredness or fatigue					

Form reviewed with patient and appropriate documentation made in the health record.

Date: _____

Initials: _____

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