Primary Health Medical Group

Account Number: ________________

Medicare Wellness Visit

(Welcome to Medicare, Annual and Subsequent Visits)

Patient Name:____ **DOB:** ______________________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

1. **Do you have little interest or pleasure in doing things?**
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Declined to specify

2. **Have you been feeling down, depressed, or hopeless?**
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Declined to specify

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3. **Please list other physicians or health care providers involved in your health care, including Vision, Dental and Home Health providers?** *If applicable list Name/Specialty below.*

☐ **I have no other physician or health care provider involved in my health care.**

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

4. **What company provides your medical supplies? (Diabetes supplies, respiratory supplies, medical equipment, other).** ☐ **N/A**

____________________________ ____________________________ ____________________________

5. **Do you wear a seat belt when you travel?**
☐ Yes ☐ No

6. **Can you get places, out of walking distance, without help? For example, can you drive your own vehicle, or can you rely on other people or use public transportation to get where you need to go?**
☐ Never ☐ Sometimes ☐ Always

7. **Does your home require improvements that would make you feel safer when getting around, such as better lighting, removing throw rugs, or adding grab bars in the bathroom?**
☐ Yes ☐ No

8. **Have you fallen more than twice in the last year?**
☐ Yes ☐ No

9. **Do you need help bathing, toileting, feeding yourself, dressing, brushing your hair/teeth, or getting around the house?**
☐ Never ☐ Sometimes ☐ Always

10. **Do you need help with housekeeping, laundry, shopping or preparing meals for yourself?**
☐ Never ☐ Sometimes ☐ Always

11. **Do you have any difficulties using the telephone?**
☐ Yes ☐ No

12. **Do you have family and/or friends that you can rely on for emotional support, such as stressful situations or loneliness?**
    ☐ Yes ☐ No
13. **Are you able to manage your own finances, banking, and pay your bills?**
    ☐ Never ☐ Sometimes ☐ Always
14. **Do you have any difficulties managing you own medications? Such as obtaining from the pharmacy, remembering to take on time, etc.**
    ☐ Never ☐ Sometimes ☐ Always
15. **Do you have any issues with leaking of urine?**
    ☐ Never ☐ Sometimes ☐ Always
16. **How often do you eat a well-balanced diet?**
    ☐ Never ☐ Sometimes ☐ Always
17. **Have you had any difficulties with sexual activity in the past month?**
    ☐ Never ☐ Sometimes ☐ Always
18. **Are you experiencing any pain? How do you rate your pain today?**
    ☐ No pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain
19. **Do you exercise for about 20 minutes, 3 or more days a week?**
    ☐ Yes, most of the time ☐ Yes, some of the time ☐ No, I usually do not exercise this much
20. **Do you engage in any of the following activities on a monthly basis: Clubs, volunteering, community groups, religious services, group or team athletics, hobbies, gathering family and/or friends?**
    ☐ Never ☐ Sometimes ☐ Always
21. **In the past month, have you struggled with increased or unusual fatigue?**
    ☐ Yes ☐ No
22. **Are you currently taking any prescription pain medication or an opioid prescription?**
    ☐ Yes ☐ No