MEDICARE WELLNESS CHECKUP

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

Your name: _____

Today's date: _____

Your date of birth: _____

1. What is your age?
   ☐ 18-64 ☐ 65-69 ☐ 70-79 ☐ 80 or older
2. Are you a male or a female?
   ☐ Male ☐ Female
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.
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 alone on buses or 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.

continued ➤

AAFP FPM

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

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.

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. 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.	☐	☐	☐	☐	☐

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

☐ Yes ☐ No.

20. Are you afraid of falling?

☐ Yes ☐ No.

21. Are you a smoker?

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

22. 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.

23. 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.

24. 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 medicines the way you have been told to take them?

- ☐ I do not have to take medicine.
- ☐ 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.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

AVANTA CLINIC LLC
Internal Medicine + Primary Care

Patient Health Questionnaire (PHQ-9)

Name: _____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Instructions: *Please circle your answer*

		Not at all	Several days	More than half 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 the reading a 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
	(Add all columns)				
	Total				

If you circled 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

AVANTA CLINIC LLC
Internal Medicine + Primary Care

Katz Activities Of Daily Living

Patient Name:_____ Date:_____

Instructions: *Please check the box for each Activity section*

Activities	**Independent** **(1 point)** **NO** supervision, direction or personal assistance	**Dependent** **(0 points)** **WITH** supervision, direction, personal assistance or total care
Bathing	☐ Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area, or disabled extremity.	☐ Needs help in bathing more than one part of the body getting out of the tub or shower. Requires total bathing.
Dressing	☐ Gets clothes from closets and drawers and puts on clothes and other garments complete with fasteners. May have help tying shoes.	☐ Needs help with dressing self or needs to be completely dressed.
Toileting	☐ Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	☐ Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
Transferring	☐ Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	☐ Needs help in moving from bed to chair or requires a complete transfer.
Continence	☐ Exercises complete self control over urination and defecation.	☐ Is partially or totally incontinent of bowel or bladder.
Feeding	☐ Gets food from plate into mouth without help. Preparation of food may be done by another person.	☐ Needs partial or total help with feeding or requires parenteral feeding.
Total Points		

AVANTA CLINIC LLC
Internal Medicine + Primary Care

Lawton Instrumental Activities of Daily Living

Patient Name:_____ Date:_____

Instructions: *Please circle the number once under each section*

(A) Ability to use Telephone	Points	(E) Laundry	Points
Operates telephone on own initiative-looks up and dials numbers, etc.	1	Does personal laundry completely	1
Dials a few well-known numbers	1	Launders small items-rinses stockings, etc.	1
Answers telephone but does not dial	1	All laundry must be done by others	0
Does not use telephone at all	0		
(B) Shopping		**(F) Mode of Transportation**	
Takes care of all shopping needs independently	1	Travels independently on public transportation or drives own car	1
Shops independently for small purchases	0	Arranges own travel via taxi, but does not otherwise use public transportation	1
Needs to be accompanied on any shopping trip	0	Travels on public transportation when accompanied by another	1
Completely unable to shop	0	Travel limited to taxi or automobile with assistance of another	0
		Does not travel at all	0
(C) Food Preparation		**(G) Responsibility for Own Medications**	
Plans, prepares and serves adequate meals independently	1	Is responsible for taking medication in correct dosages at correct time	1
Prepares adequate meals if supplied with ingredients	0	Takes responsibility if medication is prepared in advance in separate dosage	0
Heats, serves and prepares meals, or prepares meals, or prepares meals but does not maintain adequate diet	0	Is not capable of dispensing own medication	0
Needs to have meals prepared and served	0		
(D) Housekeeping		**(H) Ability to Handle Finances**	
Maintains house alone or with occasional assistance (e.g. "heavy work domestic help")	1	Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income	1
Performs light daily tasks such as dish washing, bed making	1	Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1
Performs light daily tasks but cannot maintain acceptable level of cleanliness	1	Incapable of handling money	0
Needs help with all home maintenance tasks	1		
Does not participate in any housekeeping tasks	0		

(For Healthcare Professional) Total Score _____

AVANTA CLINIC LLC
Internal Medicine + Primary Care

Hearing Screening Test

Name: _____ Date:_____

Instructions: *Please check the most box for each question*

	Yes (4 points)	Sometimes (2 points)	No (0 points)
Does a hearing problem cause you to feel embarrassed when you meet new people?	☐	☐	☐
Does a hearing problem cause you to feel frustrated when talking to members of your family?	☐	☐	☐
Do you have difficulty hearing when someone speaks in a whisper?	☐	☐	☐
Do you feel impaired by a hearing problem?	☐	☐	☐
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	☐	☐	☐
Does a hearing problem cause you to attend religious services less often than you would like?	☐	☐	☐
Does a hearing problem cause you to have arguments with family members?	☐	☐	☐
Does a hearing problem cause you difficulty when listening to the television or radio?	☐	☐	☐
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	☐	☐	☐
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐	☐	☐
(Add all columns)	_____	_____	
Total	_____		

0 to 8 = 13 percent probability of hearing impairment (no handicap/no referral);
10 to 24 = 50 percent probability of hearing impairment (mild to moderate handicap/referral);
26 to 40 = 84 percent probability of hearing impairment (severe handicap/referral).

AVANTA CLINIC LLC
Internal Medicine + Primary Care

Fall Risk Screening

Name: _____ Date:_____

Two or more falls in the prior 12 months?	Yes	No
Presenting with acute fall?	Yes	No
Difficulty with walking or balancing?	Yes	No

Home Safety Screening

What is your living situation?

- ❑ Alone
- ❑ With my spouse or family
- ❑ With a friend or room mate
- ❑ In a Nursing Home or Assisted Living Facility
- ❑ I don't have a place to live

Does your home have working smoke alarms?

- ❑ Yes
- ❑ No
- ❑ I don't know
- ❑ Not Applicable

AVANTA CLINIC LLC
Internal Medicine + Primary Care

The 3 Incontinence Questions

Name: _____ Date:_____

1. During the past three months, have you leaked urine (even a small amount)?

- ❑ Yes
- ❑ No ***(questionnaire completed)***

2. During the past three months, did you leak urine: ***(check all that apply)***

- ❑ When you were performing some physical activity, such as coughing, sneezing, lifting, or exercising?
- ❑ When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?
- ❑ Without physical activity and without a sense of urgency?

3. During the past three months, did you leak urine most often: ***(check only one)***

- ❑ When you were performing some physical activity, such as coughing, sneezing, lifting, or exercising?
- ❑ When you had the urge or feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?
- ❑ Without physical activity and without a sense of urgency?
- ❑ About equally as often with physical activity as with a sense of urgency?