OLYMPIC
INTERNAL MEDICINE, INC. P.S.

Name: _____Date: _____ Date of Birth: _____

A Checklist for Your Medicare Wellness Annual Visit

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

1. 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

2. 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

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

4. During the past 4 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

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

	Yes	No
6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi or drive your own car?		
7. Can you shop for groceries or clothes without help?		
8. Can you prepare your own meals?		
9. Can you do your own housework without help?		
10. Can you handle your own money without help?		
11. Do you need help eating, bathing, dressing, or getting around your home?		

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

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

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

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

□ Yes, usually □ Yes, sometimes □ No

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

	Never	Seldom	Sometimes	Always/often
Fall or dizzy when standing up	□	□	□	□
Sexual problems	□	□	□	□
Trouble eating well	□	□	□	□
Teeth or dentures	□	□	□	□
Problems using the telephone	□	□	□	□
Tired or fatigued	□	□	□	□

	Yes	**No**
17. Do you have hearing loss?		
18. Have hearing aid(s) ever been recommended for you?		
19. Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?		
20. Do you sometimes feel that people are mumbling or not speaking clearly?		
21. Do you experience difficulty following dialogue in the theater or while watching TV?		
22. Do you sometimes have difficulty understanding speech on the telephone?		
23. Do you experience ringing or noises in your ears?		
24. Do you hear better with one ear than the other?		

25. Have you fallen 2 or more times in past year?

□ Yes □ No

26. Do you have a home on one level?

□ Yes □ No

If not how many stairs are in your home? _____

27. Are you afraid of falling?

□ Yes □ No

28. Are you a smoker?
- □ No
- □ Yes and I might quit
- □ Yes, but I'm not ready to quit

29. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have?
- □ 10 or more per week
- □ 6-9 per week
- □ 2-5 per week
- □ 1 drink or less per week
- □ No alcohol at all

30. 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

31. Have you been given any information to help you with the following?

* Hazards in your home that might hurt you?

□ Yes □ No

* Keeping track of your medications?

□ Yes □ No

32. How often do you have trouble taking medicine 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

33. 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

The name of all your doctors:

Name:	Specialty

Have any of your close relatives had any health changes? □ Yes □ No

Are you worried about your memory? □ Yes □ No

Have you had any recent immunizations? □ Yes □ No
If yes, please list: _____

Do you have a living will or advance directive? □ Yes □ No
(If you have one, please bring a copy of it with you)

If not, would you like more information about living wills or advanced directives? □ Yes □ No

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