MEDICARE WELLNESS QUESTIONNAIRE

Patient Name: ________________________________
Patient DOB: __________________________________
Today's Date: ________________________________

ADVANCE DIRECTIVES

1. Do you have a durable power of attorney for healthcare?
   YES NO

2. Do you have a living will?
   YES NO

3. Would you like more information about a living will and durable power of attorney?
   YES NO

PAIN

On a scale of 1-10 are you having pain today?
(1 being the lowest and 10 being the highest)
YES NO

1. If yes, where is the pain located?

2. When did your pain start?

3. Please circle one- which best describes your type of pain?

Aching	Sharp
Burning	Shooting
Discomforting	Stabbing
Dull	Throbbing
Gnawing	Tingling
Piercing	

FALL RISK

1. Have you fallen in the last year?
   YES NO

2. If yes, how many times have you fallen?

3. Did the fall(s) result in an injury?
   YES NO

4. If yes, please describe:
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____

QUALITY OF LIFE

Over the last 2 weeks how often have you been bothered by any of the following problems? (circle one)

1. Little interest or pleasure in doing things
   Not at all Several days
   More than half the days Nearly every day

2. Feeling down, depressed or hopeless
   Not at all Several days
   More than half the days Nearly every day

FUNCTIONAL ABILITY, SAFETY, HOME ENVIRONMENT

1. Are you able to climb stairs? (circle one)
   ABLE TO NOT ABLE TO FIND IT DIFFICULT

2. Are you able to exercise? (circle one)
   ABLE TO NOT ABLE TO FIND IT DIFFICULT

3. Are you able to get in and out of the cars?
   ABLE TO NOT ABLE TO FIND IT DIFFICULT

4. Are you able to go downstairs?
   ABLE TO NOT ABLE TO FIND IT DIFFICULT

5. Are you able to go upstairs?
   ABLE TO NOT ABLE TO FIND IT DIFFICULT

6. Are you able to kneel?
   ABLE TO NOT ABLE TO FIND IT DIFFICULT

7. Are you able to perform activities of daily living?
   ABLE TO NOT ABLE TO FIND IT DIFFICULT

8. Are you able to put on socks and shoes?
   ABLE TO NOT ABLE TO FIND IT DIFFICULT

9. Are you able to walk?
   ABLE TO NOT ABLE TO FIND IT DIFFICULT

10. Are you able to walk 10 blocks?
    ABLE TO NOT ABLE TO FIND IT DIFFICULT

11. Are you able to walk an unlimited distance?
    ABLE TO NOT ABLE TO FIND IT DIFFICULT

12. Are you able to walk 5 to 10 blocks?
    ABLE TO NOT ABLE TO FIND IT DIFFICULT

MEDICARE WELLNESS QUESTIONNAIRE

Patient Name: ___________________________________
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FUNCTIONAL ABILITY, SAFETY, HOME ENVIRONMENT, CONT'D

13. Do you need help with activities of daily living?
    YES NO
14. Do you have smoke detectors in your home?
    YES NO
15. Do you have firearms in your home?
    YES NO
    If yes, please answer the questions below.
    - How many do you have in your home?
      ____
    - Are your firearms locked?
      YES NO
    - Do you use a trigger guard on the firearms?
      YES NO
    - Do you store your ammunition separately from the firearm(s)?
      YES NO
    - Are your firearms unloaded for storage?
      YES NO
    - Your firearms are kept for: (Please circle all that apply)
      Recreation Occupation
      Hunting Protection
16. Do you use a seatbelt in a vehicle?
    YES NO
17. Do you have carbon monoxide detectors in your home?
    YES NO
18. Is there Radon in your home? (Circle one)
    Treated Untested
19. What type of home heating do you have? (Circle one)
    Coal Oil
    Electric Solar
    Gas Wood

NUTRITION

1. What type of diet do you follow? (Circle one)
   Mayo Clinic Diet Nutrisystem
   Dash Diet Jenny Craig
   Weight Watchers Healthy
   Low Fat Vegan
   Biggest Loser Vegetarian
   Mediterranean Diet Other ______________
2. Do you use a Calcium supplement?
   YES NO
   If yes, how many mg. per day? ___________________
3. Do you take a daily multivitamin?
   YES NO
4. Do you take a Vitamin D supplement?
   YES NO
5. Do you take Folic Acid?
   YES NO

TOBACCO AND ALCOHOL

1. Do you use Tobacco? (circle one)
   YES NO FORMER
2. Do you have passive smoke exposure? (circle one)
   YES NO FORMER
3. Do you have passive vaping exposure? (circle one)
   YES NO FORMER
4. Do you drink alcohol?
   YES NO
   If yes, please answer the questions below.
   - If yes, what type(s) circle all that apply:
     Beer Rum
     Beer and Liquor Scotch
     Beer and Wine Vodka
     Gin Whiskey
     Hard Liquor Wine
   - How frequently do you drink alcohol? (circle one)
     Daily Occasionally
     Weekly Rarely
     Monthly Socially
     Yearly
   - How much alcohol do you think you drink at one time? (circle one)
     1 Drink 6 Drinks
     2 Drinks 7 or more Drinks
     3 Drinks 1 Fifth
     4 Drinks 1 Pint
     5 Drinks
   - When was your last drink? (circle one)
     Today Last Night
     Yesterday Last Month
     Last Week Two weeks ago
     One Year Ago

   How many times in the past year have you had 4 or more drinks in a day?_______

MEDICARE WELLNESS QUESTIONNAIRE

Physician: ____________________________
Visit Date: _______________

COMMUNITY LINKAGES SURVEY

We are dedicated to you, our patient and your family. If you are comfortable, please take a moment to answer the following questions so that we can help connect you with local community resources. Our staff is ready to answer any additional questions that you may have.

Please check ☑ Yes or No to the following questions:

1. In the past month, did **poor physical or mental health** keep you from doing your usual activities, like work, school or a hobby? ☐ Yes or ☐ No
2. In the past year, was there a time when you needed to see a doctor but could not because it **cost** too much? ☐ Yes or ☐ No
3. Do you ever eat less than you feel you should because there is not enough **food**? ☐ Yes or ☐ No
4. Do you need a job or other **steady source of income**? ☐ Yes or ☐ No
5. Are you worried that in the next few months, you may not have adequate **housing** that you own, rent or share? ☐ Yes or ☐ No
6. In the past year, have you had a hard time paying your utility company **bills**? ☐ Yes or ☐ No
7. Does getting **child care** make it hard for you to work, go to school or study? ☐ Yes or ☐ No
8. Do you think completing more **education or training**, like earning a high school diploma, going to college, or learning a trade, would be helpful for you? ☐ Yes or ☐ No
9. Do you need a dependable **way to get to work or school** and your appointments? ☐ Yes or ☐ No
10. Do you need **household supplies**? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo. ☐ Yes or ☐ No
11. If you take **medication**, are you not taking it because it is too expensive? ☐ Yes or ☐ No
12. Do you need help **finding or paying for care for loved ones**? For example, child care or day care for an older adult. ☐ Yes or ☐ No
13. Do you ever **feel unsafe** in your home or living situation? ☐ Yes or ☐ No
    - If you answered ☑ Yes, would you like to receive assistance with any of these needs? ☐ Yes or ☐ No
    - Are any of your needs **urgent**, please write the Number of the Need (1-11)? _______

My name: ________________________________
Date of Birth: __________________

Survey completed by (if other than the patient):
____

My best telephone number:

____

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Patient Name: ___________________________________
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Please list all specialty Physicians that you have seen in the last year:

Provider Name: ____________________________________

Specialty: ____

Phone Number: _____________________________________

Reason/Diagnosis: __________________________________

Provider Name: ____________________________________

Specialty: ____

Phone Number: _____________________________________

Reason/Diagnosis: __________________________________

Provider Name: ____________________________________

Specialty: ____

Phone Number: _____________________________________

Reason/Diagnosis: __________________________________

Provider Name: ____________________________________

Specialty: ____

Phone Number: _____________________________________

Reason/Diagnosis: __________________________________

Provider Name: ____________________________________

Specialty: ____

Phone Number: _____________________________________

Reason/Diagnosis: __________________________________