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

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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 unlocked 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?_________
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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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: ___________________________________
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