WELL SENIOR

MEDICAL / SURGICAL UPDATES SINCE LAST VISIT

_____

_____

FAMILY HISTORY UPDATES SINCE THE LAST VISIT

_____

_____

PREVENTION

	month / year	*result*
Cholesterol	_____	_____
Colonoscopy / Stool Blood Test	_____	_____
Prostate Evaluation	_____	_____
Bone Density Screening	_____	_____
Mammogram	_____	_____
Pap Smear	_____	_____
Flu Shot in last year?	_____	
Tetanus/Tdap in last 10 years?	_____	
Pneumonia vaccine?	_____	
Shingles (Zoster) vaccine?	_____	

Tobacco Use
Type: _____ Amount: _____ Years: _____ Ready to Quit? _____

Alcohol Use:
Frequency: _____ Amount: _____ Ready to Quit? _____

Drug Use:
Frequency: _____ Type: _____ Prior Use: _____ Ready to Quit? _____

SYMPTOMS

Joint pain	YES	NO	Chest pain	YES	NO
Sexual concerns	YES	NO	Shortness of breath	YES	NO
Change in stools	YES	NO	Stomach problems	YES	NO
Urinary concerns	YES	NO	Weight gain/loss	YES	NO
Poor Sleep	YES	NO	Easy Bruising	YES	NO
Generalized weakness	YES	NO	Difficulty with hearing	YES	NO

OVER →

MEDICARE WELLNESS QUESTIONAIRE

The Medicare Wellness exam is intended to address only preventive care and safety concerns. It does **NOT COVER** evaluation of NEW OR ONGOING medical problems. Due to this, it often includes an office visit fee.

How would you rate your PHYSICAL HEALTH? Excellent Good Poor

How would you rate your MENTAL HEALTH? Excellent Good Poor

Do you have trouble with your vision? YES NO **Does it bother you or others?** YES NO

Do you have trouble hearing? YES NO **Does it bother you or others?** YES NO

Can you perform day to day tasks without help? YES NO

(Circle anything you have difficulty with)

Bathing	Transferring	Telephone Use	Housekeeping	Laundry
Dressing	Eating	Taking Medicines	Personal Finance	Shopping
Grooming / Hygiene	Continence	Food Preparation	Transportation	

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

	None	*several days*	*more than half*	*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

Do you have problems with concentration, memory, or making decisions? YES NO

Do you have excessive worry or stress in your life? YES NO

Where do you live?

APARTMENT ASSISTED LIVING HOUSE NURSING HOME SENIOR LIVING TRAILER

Do you feel safe at home? YES NO

Who would help if you became ill or injured?

SPOUSE CAREGIVER CHILDREN FRIEND NEIGHBOR NONE

Do you have smoke & carbon monoxide detectors? YES NO

Do you have safety bars in bathroom (if needed)? YES NO

Do you take your medications for reasons other than what they are prescribed for? YES NO

Would your family feel safe riding in a car if you were driving? YES NO

How many times have you fallen in last year? _____ **Were you injured?** YES NO

Do you use a cane or walker consistently (if needed)? YES NO

Are you able to eat well? YES NO

Have you lost or gained weight without trying in the last year? YES NO

How would you describe your diet?

HEALTHY PORTIONS TOO BIG TOO MUCH SUGAR TOO MUCH FAT

Do you participate in activities to increase your heart rate at least twice per week? YES NO

Do you participate in strength-building activities at least twice per week? YES NO

SPECIALISTS *(please list any specialists you see)*

Cardiology _____ Pulmonology _____

Nephrology _____ Neurology _____

Gastroenterology _____ Orthopedics _____

Gynecology _____ Oncology _____

Urology _____ Dermatology _____

Other _____ Other _____

Do you have a living will?	YES	NO	
Do you have a medical power of attorney?	YES	NO	Who:
Do you have or desire a do not resuscitate order (DNR)?	YES	NO	