MEDICARE WELLNESS VISIT FORM

Please bring Pages 1 through 3 with you to your appointment

St. Peter's Health MEDICAL GROUP

Name				**Date**	
DOB		**Preferred Pharmacy**			
Other Specialty Providers (Provider name & area of specialty)			1. 2. 3.		4. 5. 6.
Ophthalmologist / Optometrist			**Name & last seen:**		
Dentist			**Name & last seen:**		

How would you say your health is: __Excellent __Very good __Good __Fair __Poor

	HOME SAFETY QUESTIONNAIRE	**Yes**	**No**
1.	Do you live alone?		
2.	Do you have stairs at your house?		
3.	Do you have adequate lighting?		
4.	Do you have rugs without non-slip backing on your floor?		
5.	Do you use a shower or tub that has grab bars or rails?		
6.	Do you have fire alarms in your house?		
7.	Do you have a telephone?		
8.	Does anyone stop by to check on you or visit?		

	FUNCTIONAL ABILITY QUESTIONNAIRE	**Yes**	**No**
1.	In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, bathing, brushing your teeth, walking, or using the toilet?		
2.	In the past 7 days, did you need help from others to take care of things such as laundry, housekeeping, banking, shopping, cooking, transportation, or taking your medications?		
3.	Have you missed any medication doses or forgotten to take your medication?		
4.	In the past 12 months, have you experienced confusion or memory loss that is happing more often or getting worse?		
5.	In the past 12 months, have family members told you that you have difficulty remembering things?		

EXERCISE
How many days a week do you usually exercise? _____ days per week
On days when you exercise, for how long do you usually exercise? _____minutes per day
How intense is your typical exercise? ☐ I am currently not exercising ☐ Light (stretching or slow walking) ☐ Moderate (brisk walking)☐ Heavy (jogging or swimming) ☐ Very heavy (fast running or stair climbing)

FALL RISK SCREEN		Yes (1 point)	No (0 points)
1.	I have fallen in the past year.		
2.	I use or have been advised to use a cane or walker to get around safely.		
3.	Sometimes I feel unsteady when I am walking		
4.	I steady myself by holding onto furniture when walking at home.		
5.	I am worried about falling.		
6.	I need to push with my hands to stand up from a chair.		
7.	I have some trouble stepping up onto a curb.		
8.	I often have to rush to the toilet.		
9.	I have lost some feeling in my feet.		
10.	I take medicine that sometimes makes me feel light-headed or more tired than usual.		
11.	I take medicine to help me sleep or improve my mood.		
12.	I often feel sad or depressed.		
Add up the number of points for each "Yes" answer. If you scored 4 points or more, you may be at risk for falling.		**Total_____**	

SOCIAL NEEDS		Yes	No
1.	In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?		
2.	In the last 12 months, has your utility company shut off your service for not paying your bills?		
3.	Are you worried that in the next 2 months, you may not have stable housing?		
4.	In the last 12 months, have you needed to see a doctor, but could not because of cost?		
5.	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?		
6.	Do you ever need help reading hospital materials?		
7.	Are you afraid you might be hurt in your apartment building or house?		
8.	If you answered YES to any questions above, would you like to receive assistance with any of these needs?		
9.	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight.		

OTHER		Yes	No
1.	Do you always wear a seat belt while in a motor vehicle?		
2.	Do you have any new sexual partners?		
3.	Do you find yourself asking people to repeat themselves?		
4.	Do others comment that your TV is turned up too loud?		
5.	Has your weight changed by more than 5 pounds in the past year?		
6.	Do you have any nutrition or weight related goals?		
7.	In the past 2 weeks, have you felt overwhelmed by stress?		
8.	In the past 2 weeks, have you had difficulty handling anger?		
9.	Do you feel that you get the social and emotional support you need? If yes, who provides this support? _____		

TOBACCO, ALCOHOL, RECREATIONAL DRUG USE		Yes	No
1.	Do you use any recreational drugs?		
2.	Do you use medical marijuana?		
3.	Do you drink alcohol? If yes, how much per day? _____		
4.	Do you use tobacco products?	_____No _____Yes, and I might quit _____Yes, but I'm not ready to quit	

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)					
Over the last 2 weeks, how often have you been bothered by any of the following problems?		**Not at all**	**Several days**	**More than half the 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/staying asleep, 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 as reading the 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
		Total: _____			
If you have checked off any problems on this questionnaire so far, how difficult has it made 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**

ADVANCE CARE PLANNING		Yes	No
1.	Do you have a living will?		
2.	Do you have a POLST (Physician Order for Life Sustaining Treatment)?		
3.	Do you have a medical POA (Power of Attorney)?		