Medicare Wellness Assessment

Patient Name: _____ Date of Birth_____ Date:_____

Nutrition/Supplments	
Do you take the following supplements?	
Calcium	__ Dietary Sources ___mg/day __Supplement __mg/day
Multivitamin	__ Daily __Occasionally
Vitamin D	__Supplement __Adequate Sunlight Exposure
Folic Acid	__ Daily __Occasionally
Diet History (circle all that apply to your current diet habits)	1600 calorie 1800 calorie 2000 calorie diabetic gluten-free healthy high calorie high fat high roughage high salt junk food low fat low residue low salt no red meat vegan vegetarian
Daily Activities	
Do you need help with activities of daily living?	___No ___Yes
Are you able to bathe yourself?	___No ___Yes
Are you able to dress yourself?	___No ___Yes
Are you able to walk?	___ without any assistance ___with an assistive device (walker, cane etc) ___ unable to walk
Have you had any falls in the last year? If so how many?	___No ___Yes _____ Number of Falls
If yes to falls, did any result in injury?	___No ___Yes
Do you have smoke detectors in your home?	___No ___Yes
Do you have firearms in your home?	___No ___Yes
Do you use a seatbelt in a vehicle?	___No ___Yes
Do you have carbon monoxide detectors in your home?	___No ___Yes
Has your home been tested or treated for radon?	___Tested ___Treated ___Neither Tested or Treated
How do you feel about your overall health?	__Excellent ___ Good ___Fair ___Poor
How would you describe your activity level?	__ moderate __sedentary __vigorous
How often do you exercise?	__2-3 times weekly __ 3-4 times weekly __daily __never __occasional

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Have you ever used tobacco? If so how many years?	___No ___Yes _____ Years used Type of Tobacco_____ (i.e cigarettes, chewing, pipe)
Are you currently using a tobacco product?	___No ___Yes Amount used each day_____(i.e 1 pack)
Do you have an Advance Directive/Power of Attorney?	___No ___Yes
Over the last 2 weeks have you been bothered by:	
Little interest or pleasure in doing things	___Not at all ___Several days ___More than half the days ___Nearly every day
Feeling down, depressed or hopeless	___Not at all ___Several days ___More than half the days ___Nearly every day
Trouble falling or staying asleep, or sleeping too much	___Not at all ___Several days ___More than half the days ___Nearly every day
Feeling tired or having little energy	___Not at all ___Several days ___More than half the days ___Nearly every day
Poor appetite or overeating	___Not at all ___Several days ___More than half the days ___Nearly every day
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	___Not at all ___Several days ___More than half the days ___Nearly every day
Trouble concentrating on tihngs, such as reading the newspaper or watching television	___Not at all ___Several days ___More than half the days ___Nearly every day
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	___Not at all ___Several days ___More than half the days ___Nearly every day
Thoughts that you would be better off dead, or of hurting yourself in some way	___Not at all ___Several days ___More than half the days ___Nearly every day
If you check off any problems in the previous questions, how difficult have these problems made it 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