MEDICARE HEALTH HISTORY FORM
for Annual Wellness Visit
Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health care possible.

Your Name_____

_____

Today's date_____

Your date of birth_____

1. What is your age?

□ 65-69. □ 70-79. □ 80 or older.

2. Are you a female or a male?

□ Male. □ Female.

3. During the **past four weeks,** how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

□ Not at all.
□ Slightly.
□ Moderately.
□ Quite a bit.
□ Extremely.

4. During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

□ Not at all.
□ Slightly.
□ Moderately.
□ Quite a bit.
□ Extremely.

5. During the **past four weeks**, how much bodily pain have you generally had?

□ No pain.
□ Very mild pain.
□ Mild pain.
□ Moderate pain.
□ Severe pain.

6. During the **past four weeks**, was someone available to help you if you needed and wanted help?

(For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

□ Yes, as much as I wanted.
□ Yes, quite a bit.
□ Yes, some.
□ Yes, a little.
□ No, not at all.

7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

□ Very heavy.
□ Heavy.
□ Moderate.
□ Light.
□ Very light.

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)

□ Yes. □ No.

9. Can you go shopping for groceries or clothes without someone's help?

□ Yes. □ No.

10. Can you prepare your own meals?

□ Yes. □ No.

11. Can you do your housework without help?

□ Yes. □ No.

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

□ Yes. □ No.

13. Can you handle your own money without help?

□ Yes. □ No.

14. During the **past four weeks**, how would you rate your health in general?

□ Excellent.
□ Very good.
□ Good.
□ Fair.
□ Poor.

continued→

Patient Name_____ DOB_____Today's Date_____

15. How have things been going for you during the **past four weeks**?

- □ Very well; could hardly be better.
- □ Pretty well.
- □ Good and bad parts about equal.
- □ Pretty bad.
- □ Very bad; could hardly be worse.

16. Are you having difficulties driving your car?

- □ Yes, often.
- □ Sometimes.
- □ No.
- □ Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?

- □ Yes, usually.
- □ Yes, sometimes.
- □ No.

18. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometime	Often	Always
Falling or dizzy when standing up	□	□	□	□	□
Sexual problems	□	□	□	□	□
Trouble eating well	□	□	□	□	□
Teeth or denture problems	□	□	□	□	□
Problems using the telephone	□	□	□	□	□
Tiredness or fatigue	□	□	□	□	□

19. Have you fallen two or more times in **the past year**?

□ Yes. □ No.

20. Are you afraid of falling?

□ Yes. □ No.

21. Are you a smoker?

- □ No.
- □ Yes, and I might quit.
- □ Yes, but I'm not ready to quit.

Checklist to bring to your appointment:

-Medical records, including immunization records
-Family health history in as much detail as possible
-Full list of medications, supplements-how often & how much taken
-Full list of current providers & suppliers involved in your care

22. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- □ 10 or more drinks per week.
- □ 6-9 drinks per week.
- □ 2-5 drinks per week.
- □ One drink or less per week.
- □ No alcohol at all.

23. Do you exercise for about 20 minutes three or more days a week?

- □Yes, most of the time.
- □Yes, some of the time.
- □No, I usually do not exercise this much.

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

□ Yes. □ No.

Keeping track of your medications?

□ Yes. □ No.

25. How often do you have trouble taking medicines the way you have been told to take them?

- □ I do not have to take medicine.
- □ I always take them as prescribed.
- □ Sometimes I take them as prescribed.
- □ I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?

- □ Very confident.
- □ Somewhat confident.
- □ Not very confident.
- □ I do not have any health problems.

27. What is your race? (**Check all that apply.**)

- □ White.
- □ Black or African American.
- □ Asian.
- □ Native Hawaiian or Other Pacific Islander.
- □ American Indian or Alaskan Native.
- □ Hispanic or Latino origin or descent.
- □ Other.

Thank you very much for completing your Medicare Health History. Please give the completed form to your doctor or nurse.