Crystal Run Healthcare
155 Crystal Run Road
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845.703.6999
www.crystalrunhealthcare.com

MEDICARE WELLNESS CHECKUP

Patient Name: ______________________________ DOB: ____________ Date: ____________

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

1. Are you a male or a female?
   - ❑ Male ❑ Female

2. 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

3. 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

4. During the **past four weeks**, how would you rate your health in general?
   - ❑ Excellent
   - ❑ Very good
   - ❑ Good
   - ❑ Fair
   - ❑ Poor

5. 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

6. During the **past four weeks**, how much bodily pain have you generally had?
   - ❑ No pain
   - ❑ Very mild pain
   - ❑ Mild pain
   - ❑ Moderate pain
   - ❑ Severe pain

7. 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

8. During the past four weeks, what was the hardest physical exercise or activity you could do for at least two minutes?
   - ❑ Very heavy (like fast running or stair climbing)
   - ❑ Heavy (like jogging or swimming)
   - ❑ Moderate (like brisk walking)
   - ❑ Light (like stretching or slow walking)
   - ❑ I do not exercise at all

9. Can you get to the places you'd like to go that are out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)
   - ❑ Yes ❑ No

10. Can you go shopping for groceries or clothes without someone's help?
    - ❑ Yes ❑ No

11. Can you prepare your own meals?
    - ❑ Yes ❑ No

12. Can you do your housework without help?
    - ❑ Yes ❑ No

13. 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

14. Can you handle your own money without help?
    - ❑ Yes ❑ No

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15. Are you having difficulties driving your car?
    - ❑ Yes, often
    - ❑ Sometimes
    - ❑ No
    - ❑ Not applicable, I do not use a car

16. Do you always fasten your seat belt when you are in a car?
    - ❑ Yes, usually
    - ❑ Yes, sometimes
    - ❑ No

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

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

18. Have you fallen two or more times in **the past year**?
    ❑ Yes ❑ No

19. Are you afraid of falling?
    ❑ Yes ❑ No

20. Are you a smoker?
    - ❑ No
    - ❑ Yes, and I might quit
    - ❑ Yes, but I'm not ready to quit

21. How often do you have trouble taking medicines the way you have been told to take them?
    - ❑ N/A 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

22. 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

23. How many hours of sleep do you usually get
    - ❑ 0-3
    - ❑ 4-6
    - ❑ 7-10
    - ❑ More than 10

24. Do you snore or has anyone told you that you snore?
    ❑ Yes ❑ No

25. During the past week how often have you felt excessively tired?
    - ❑ Often
    - ❑ Sometimes
    - ❑ Almost never
    - ❑ Never

26. Many people experience leakage of urine, also called urinary incontinence. In the past six months have you experienced this?
    ❑ Yes ❑ No

27. Do you have any problems with your vision?
    ❑ Yes ❑ No

28. Do you wear contact lenses or glasses?
    ❑ Yes ❑ No

29. Do you have any trouble with your hearing?
    ❑ Yes ❑ No

30. Do you use hearing aids or other devices to help you to hear?
    ❑ Yes ❑ No

31. Have you experienced any problems with memory or thinking?
    ❑ Yes ❑ No

32. Do any family members or friends report that you have difficulty remembering things?
    ❑ Yes ❑ No

33. Do you have an Advanced Directive, living will, or power of attorney for health care, in the case that an injury or illness causes you to be unable to make healthcare decisions?
    ❑ Yes ❑ No

34. Do you have any worries or concerns with any of the following?
    - ❑ Yes ❑ No Stable/Safe Housing
    - ❑ Yes ❑ No Access to Food
    - ❑ Yes ❑ No Transportation