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Medicare Wellness Checkup

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

Name: _____ Date of Birth: ____ / _____ / _____
Today's Date: ____ / _____ / _____

1. What is your current age? ☐ 65-69 ☐ 70-79 ☐ age 80 +
2. I am ☐ Male ☐ Female
3. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, downhearted or blue?
   ☐ Not at all. ☐ Slightly. ☐ Moderately. ☐ Quite a bit. ☐ Extremely.

4. During the past 4 weeks, have 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 4 weeks, how much bodily pain have you generally had?
   ☐ No Pain. ☐ Very Mild. ☐ Mild. ☐ Moderate. ☐ Severe.

6. During the past 4 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. ☐ No, not at all.

7. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
   ☐ Very heavy. ☐ Heavy. ☐ Moderate. ☐ Very light. ☐ 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 vehicle?). ☐ Yes. ☐ No

9. Can you go grocery shopping or run errands without someone helping you?
   ☐ Yes. ☐ No

10. Can you prepare your own meals? ☐ Yes. ☐ No.

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11. Can you complete your housework without someone helping you? ☐ 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 your home?
☐ Yes. ☐ No.

13. Can you manage your own finances without help? ☐ Yes ☐ No.

14. During the past 4 weeks, how would you rate your health in general?
☐ Excellent. ☐ Very good. ☐ Good. ☐ Fair. ☐ Poor

15. How have you been during the last 4 weeks?
☐ Very well; could hardly be better
☐ Pretty well
☐ Good/Bad parts about equal
☐ Pretty bad
☐ Very bad; could hardly be worse

16. Are you having difficulty driving your vehicle?
☐ Yes, often. ☐ Sometimes. ☐ No. ☐ Not applicable, I no longer drive

17. Do you always fasten your seatbelt when you are in a vehicle?
☐ Yes, usually. ☐ Yes, sometimes. ☐ No.

18. How often during the past 4 weeks have you been bothered by any of the following problems?

Falling or dizzy when standing up. ☐ Never. ☐ Seldom. ☐ Sometimes. ☐ Often. ☐ Always.

Sexual Problems ☐ Never. ☐ Seldom. ☐ Sometimes. ☐ Often. ☐ Always

Falling or dizzy when standing up. ☐ Never. ☐ Seldom. ☐ Sometimes. ☐ Often. ☐ Always

Trouble eating well ☐ Never. ☐ Seldom. ☐ Sometimes. ☐ Often. ☐ Always
Falling or dizzy when standing up. ☐ Never. ☐ Seldom. ☐ Sometimes. ☐ Often. ☐ Always
Teeth or denture problems. ☐ Never. ☐ Seldom. ☐ Sometimes. ☐ Often. ☐ Always
Problems using the phone. ☐ Never. ☐ Seldom. ☐ Sometimes. ☐ Often. ☐ Always
Tiredness or Fatigue. ☐ Never. ☐ Seldom. ☐ Sometimes. ☐ Often. ☐ Always

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19. Have you fallen 2 or more times 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

22. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have? ☐ 10 or more drinks per week. ☐ 6-9. ☐ 2-5.
☐ 1 drink or less. ☐ None

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 don't exercise much

24. Have you been given any information to help you with the following:
Hazards in your home 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
☐ None at all

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
☐ Hawaiian or other Pacific Islander
☐ American Indian or Alaskan Native
☐ Hispanic or Latino origin or decent
☐ Other

Thank you very much for completing your Medicare Wellness Checkup.

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Patient Privacy Signature Form

I understand that under the Health Insurance Portability and Accountability Act (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up amongst healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review or given such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime at their address to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are NO required to agree to my requested restrictions, but if you DO agree, then you are bound to abide my such restrictions.

Patient's Name (PRINT): _____

Date: _____/_____/_____

Patient's Signature: _____

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Authorization

I hereby authorize my physician to release any information acquired in the course of my treatment to my insurance company. I request that payment of authorized benefits be made either to me or on my behalf for any services furnished to me by my physician (MEDICARE PATIENTS). I authorize any holder of medical or other information about me to release to the HEALTH CARE FINANCIING ADMINISTRATION and its agent any information needed to determine these benefits for related services.

Date: ___/____/_____ Signature: _____

I authorize Concierge Internal Medicine to use and disclose a copy of health and medical information if I am unable to communicate to the following:

Name of Recipient: _____

Tel: _____

_____ I authorized that messages can be left on a voicemail such as test results and/or messages that may contain personal information.

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The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit_____

Over the past 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 ○	2 ○
2. Feeling down, depressed or hopeless	0 ○	1 ○	2 ○	2 ○
3. Trouble falling asleep, staying asleep, or sleeping too much	0 ○	1 ○	2 ○	2 ○
4. Feeling tired or having little energy	0 ○	1 ○	2 ○	2 ○
5. Poor appetite or overeating	0 ○	1 ○	2 ○	2 ○
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0 ○	1 ○	2 ○	2 ○
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ○	1 ○	2 ○	2 ○
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 ○	2 ○
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 ○	1 ○	2 ○	2 ○

ADD Columns _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those 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

Submit