

## MEDICARE WELLNESS CHECKUP

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

1. What is your age?

- 65-69.    70-79.    80 or older.

2. Are you a male or a female?

- 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.

Your name: \_\_\_\_\_

Today's date: \_\_\_\_\_

Your date of birth: \_\_\_\_\_

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 or 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 ►

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	Sometimes	Often	Always
Falling or dizzy when standing up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble eating well.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth or denture problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems using the telephone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness or fatigue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

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 Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_

SERVICE	LIMITATIONS	RECOMMENDATION	SCHEDULED
<p><i>Cardiovascular screening blood tests (every 5 years)</i></p> <ul style="list-style-type: none"> <li>• Total cholesterol</li> <li>• High-density lipoproteins</li> <li>• Triglycerides</li> </ul>	<p>Order as a panel if possible.</p>		
<p><i>Diabetes screening tests (at least every 3 years, Medicare covers annually or at 6-month intervals for prediabetic patients)</i></p> <ul style="list-style-type: none"> <li>• Fasting blood sugar (FBS) or glucose tolerance test (GTT)</li> </ul>	<p>Patient must be diagnosed with one of the following:</p> <ul style="list-style-type: none"> <li>• Hypertension</li> <li>• Dyslipidemia</li> <li>• Obesity (BMI <math>\geq 30</math> kg/m<sup>2</sup>)</li> <li>• Previous elevated impaired FBS or GTT</li> </ul> <p>... or any two of the following:</p> <ul style="list-style-type: none"> <li>• Overweight (BMI <math>\geq 25</math> but <math>&lt; 30</math>)</li> <li>• Family history of diabetes</li> <li>• Age 65 years or older</li> <li>• History of gestational diabetes or birth of baby weighing more than 9 pounds</li> </ul>		
<p><i>Abdominal aortic aneurysm screening (once)</i></p> <ul style="list-style-type: none"> <li>• Sonogram</li> </ul>	<p>Patient must be referred through IPPE and not have had a screening for abdominal aortic aneurysm before under Medicare. Limited to patients who meet one of the following criteria:</p> <ul style="list-style-type: none"> <li>• Men who are 65-75 years old and have smoked more than 100 cigarettes in their lifetime</li> <li>• Anyone with a family history of abdominal aortic aneurysm</li> <li>• Anyone recommended for screening by the USPSTF</li> </ul>		
<p><i>HIV screening (annually for increased risk patients)</i></p> <ul style="list-style-type: none"> <li>• HIV-1 and HIV-2 by EIA, ELISA, rapid antibody test or oral mucosa transudate</li> </ul>	<p>Patient must be at increased risk for HIV infection per USPSTF guidelines or pregnant. Tests covered annually for patients at increased risk. Pregnant patients may receive up to 3 tests during pregnancy.</p>		
<p><i>Smoking cessation counseling (up to 8 sessions per year)</i></p> <ul style="list-style-type: none"> <li>• Counseling greater than 3 and up to 10 minutes</li> <li>• Counseling greater than 10 minutes</li> </ul>	<p>Patients must be asymptomatic of tobacco-related conditions to receive as a preventive service.</p>		
<p><i>Subsequent annual wellness visit</i></p>	<p>At least 12 months since last AWW</p>		

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

1. Recommendation of American Cancer Society; see <http://www.uspreventiveservicestaskforce.org/3rduspstf/cervcan/cervcanrr.htm#clinical> for more information.



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Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Create two copies of this page: One for your charts and one to give to your patient.

**COUNSELING AND REFERRAL OF OTHER PREVENTIVE SERVICES**  
*(Italic type indicates deductible and co-insurance are waived.)*

SERVICE	LIMITATIONS	RECOMMENDATION	SCHEDULED
<b>Vaccines</b> <ul style="list-style-type: none"> <li>• Pneumococcal (once after 65)</li> <li>• Influenza (annually)</li> <li>• Hepatitis B (if medium/high risk)</li> </ul>	Medium/high risk factors: End-stage renal disease Hemophiliacs who received Factor VIII or IX concentrates Clients of institutions for the mentally retarded Persons who live in the same house as a HepB virus carrier Homosexual men Illicit injectable drug abusers		
<i>Mammogram (biennial age 50-74)</i>	Annually (age 40 or over)		
<i>Pap and pelvic exams (up to age 70 and after 70 if unknown history or abnormal study last 10 years)</i>	Every 24 months except high risk		
Prostate cancer screening (annually to age 75) Digital rectal exam (DRE) Prostate specific antigen (PSA)	Annually (age 50 or over), DRE not paid separately when covered E/M service is provided on same date		
Colorectal cancer screening (to age 75) <ul style="list-style-type: none"> <li>• Fecal occult blood test (annual)</li> <li>• Flexible sigmoidoscopy (5y)</li> <li>• Screening colonoscopy (10y)</li> <li>• Barium enema</li> </ul>			
Diabetes self-management training (no USPSTF recommendation)	Requires referral by treating physician for patient with diabetes or renal disease. 10 hours of initial DSMT sessions of no less than 30 minutes each in a continuous 12-month period. 2 hours of follow-up DSMT in subsequent years.		
<i>Bone mass measurements (age 65 &amp; older, biennial)</i>	Requires diagnosis related to osteoporosis or estrogen deficiency. Biennial benefit unless patient has history of long-term glucocorticoid tx or baseline is needed because initial test was by other method.		
Glaucoma screening (no USPSTF recommendation)	Diabetes mellitus, family history African American, age 50 or over Hispanic American, age 65 or over		
<i>Medical nutrition therapy for diabetes or renal disease (no recommended schedule)</i>	Requires referral by treating physician for patient with diabetes or renal disease. Can be provided in same year as diabetes self-management training (DSMT), and CMS recommends medical nutrition therapy take place after DSMT. Up to 3 hours for initial year and 2 hours in subsequent years.		