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NORTHSIDE HOSPITAL

Northside Family Medicine & Urgent Care

(must be viewed by physician, signed and dated)

Patient's name: _____ **Date of Birth:** _____

Medicare B eligibility date: _____ **Today's 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. What is your age? ☐ 65-69 ☐ 70-79 ☐ 80 or older
2. Are you a female or 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

HEALTH RISK ASSESSMENT

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 in 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

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?

Please indicate with: Never, Seldom, Sometimes, Often or 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

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 ☐ Sometimes I take them as prescribed
☐ I always 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 ☐ Not very confident
☐ Somewhat 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 Alaska 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.

Provider signature: _____ Date: _____