Dear Patient,

Please complete this checklist before seeing a member of our clinical staff. Your answers will help your healthcare provider plan your future care.

1. What is your age?
   - 65-69
   - 70-79
   - 80 or older
   - Other

2. Are you a female or a male?
   - Female
   - Male

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 along 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

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. 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. 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.

22. 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.

23. 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

24. How often do you have trouble taking medications the way you have been told to take them?
   □ I do not have to take medications.
   □ I always take them as prescribed.
   □ Sometimes I take them as prescribed.
   □ I seldom take them as prescribed.

25. 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.

26. 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.

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

<table>
<thead>
<tr>
<th>Problem</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
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<tbody>
<tr>
<td>Falling or dizzy when standing up</td>
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<td>Sexual Problems</td>
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<td>Trouble eating well</td>
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<td>Teeth or denture problems</td>
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<td>Problems using the telephone</td>
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<td>Tiredness or fatigue</td>
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Form reviewed with patient and appropriate documentation made in the health record.

Date: ____________
Initials: ____________

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Please list all of your health care providers (cardiologist, dermatologist, pulmonologist, etc.)

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<tr>
<th>Provider name</th>
<th>Specialty</th>
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Please list your suppliers of health care services (organizations providing oxygen, diabetes testing supplies, wheelchair etc.)

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