IPPE AND MEDICARE ANNUAL WELLNESS – HEALTH QUESTIONNAIRE

Dear Patient,					
Please complete this checklist before seeing a	Your Name:				
member of our clinical staff. Your answers will help your healthcare provider plan your future care.	Today's Date				
your realtricare provider plan your ruture care.					
1. What is your age?	Your Date of Birth:				
□ 65-69 □ 70-79	7. During the past four weeks , what was the				
\square 80 or older \square other	hardest physical activity you could do for at				
2. Are you a female or a male?	least two minutes?				
□ Female □ Male	□ Very heavy				
3. During the past four weeks , how much have	□ Heavy				
you been bothered by emotional problems such	□ Moderate				
as feeling anxious, depressed, irritable, sad or	□ Light				
downhearted and blue?	□ Very light				
□ Not at all	8. Can you get to places out of walking distance				
□ Slightly	without help? For example can you travel along				
□ Moderately	on buses, taxis or drive your own car?				
□ Quite a bit	□ Yes. □ No.				
□ Extremely	9. Can you go shopping for groceries or clothes				
4. During the past four weeks , has your physical	without someone's help?				
and emotional health limited your social	□ Yes. □ No.				
activities with family, friends, neighbors or	10. Can you prepare your own meals?				
groups?	□ Yes. □ No.				
□ Not at all	11. Can you do your housework without help?				
□ Slightly	□ Yes. □ No.				
□ Moderately	12. Because of any health problems, do you				
□ Quite a bit	need the help of another person with your				
□ Extremely	personal care needs such as eating, bathing,				
5. During the past four weeks , how much bodily	dressing or getting around the house?				
pain have you generally had?	□ Yes. □ No.				
□ No pain□ Very mild pain	13. Can you handle your own money without				
	help?				
□ Mild pain□ Moderate pain	□ Yes. □ No.				
□ Severe pain	14. During the past four weeks , how would you				
6. During the past four weeks , was someone	rate your health in general?				
available to help you if you needed and wanted	□ Excellent				
help? (For example, if you felt very nervous,	□ Very Good				
lonely or blue; got sick and had to stay in bed;	□ Good				
needed someone to talk to; needed help with	□ Fair				
daily chores; or needed help just taking care of	□ Poor				
yourself.)	15. How have things been going for you during				
□ Yes, as much as I wanted	the past four weeks?				
□ Yes, quite a bit	□ Very Well; could hardly be better.				
□ Yes, some	□ Pretty well.				
□ Yes, a little	☐ Good and bad parts about equal.				
□ No, not at all	 □ Pretty bad. □ Verv bad: could hardly be worse. 				
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 16. Are you having difficulties driving your car? □ Yes, often. □ Sometimes. □ No. □ Not applicable, I do not use a car. 	26. How confident are you that you can control and manage most of your health problems? □ Very Confident. □ Somewhat confident. □ Net your confident					
17. Do you always fasten your seat belt when	□ Not very confident.					
you are in a car?	☐ I do not have any health problems.					
	27. What is your race? (Check all that apply)					
□ Yes, usually.	□ White.					
□ Yes, sometimes.	□ Black or African American.					
□ No.	□ Asian.					
18. Have you fallen two or more times in the	□ Native Hawaiian or Other Pacific					
past year?	Islander.	ما:مـم	a. Ala	امماما	NI - + 1	_
□ Yes. □ No.	☐ American Indian or Alaskan Native.					
19. Are you afraid of falling?	☐ Hispanic or Latino origin or descent.					
□ Yes. □ No.	□ Other.					
20. Are you a smoker?	20.11					
□ No.	28. How often during the past four weeks have					
□ Yes, and I might quit.	you been bothered by	y any	of the	tollov	wing	
☐ Yes, but I'm not ready to quit.	problems?					
21. During the past four weeks , how many						
drinks of wine, beer, or other alcoholic						
beverages did you have?			_	mes		
□ 10 or more drinks per week.		ē	Seldom	neti	u.	ays
□ 6-9 drinks per week.		Never	Selc	Sometimes	Often	Always
□ 2-5 drinks per week.	Falling or dizzy					
☐ One drink or less per week.	Falling or dizzy					
□ No alcohol at all.	when standing up					
22. Do you exercise for about 20 minutes three	Sexual Problems					
or more days a week?	Trouble eating well					
□ Yes, most of the time.	Teeth or denture					
□ Yes, some of the time.	problems					
□ No, I usually do not exercise this	Problems using the					
much.	telephone					
23. Have you been given any information to	Tiredness or fatigue					
help you with the following:						
Hazards in your house that might hurt	Form reviewed with patient and appropriate					
you?	documentation made in the health record.					
you. □ Yes □No						
Keeping track of your medications?	Date:					
□ Yes □No	Initials:					
25. How often do you have trouble taking						
medications the way you have been told to take	The contents of this M	edicar	e Wel	lness (Check	up
them?	are derived from		. 1			
□ I do not have to take medications.	http://www.HowsYou	rHeal	th.org	; Copy	right	
	□□2012 The Trustees of Dartm	outh (College	o and I	CNV	
□ I always take them as prescribed.□ Sometimes I take them as prescribed.			_			anc
□ I seldom take them as prescribed.	Corporation. Reprinted by permission. Physicians may duplicate for use in their own practices.					

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Please list all of your health care providers (cardiologist, dermatologist, pulmonologist, etc.)		
Provider name	Specialty	
Please list your suppliers of health catesting supplies, wheelchair etc.)	are services (organizations providing oxygen, diabetes	