Baylor Scott & White HEALTH

MEDICARE WELLNESS VISIT QUESTIONNAIRE

Patient Name: _____ **DOB:** _____

HEALTH STATUS

In general, how would you rate your overall health?

Excellent	Good	Poor

In general, how would you rate your overall emotional/mental health?

Excellent	Good	Poor

VISION & HEARING

Do you have trouble hearing?

No	Yes, but it doesn't bother me or others	Yes, and it is an issue for me and/or others

FUNCTIONAL ABILITY

Do you need assistance with any of the following?

Grooming	Housekeeping	Getting dressed	Shopping
Bathing	Preparing meals	Using the toilet	Using the phone
Eating	Managing money	Doing laundry	I don't need assistance

MOOD

Because of physical/mental conditions, do you have difficulty concentration, remembering or making decisions?

Yes	No

Do you have excessive worry or stress in your life?

Yes	No

HOME & SAFETY

Where do you live?

Apartment	Assisted living	Nursing home	House	Senior living facility	Trailer

Do you feel safe at home?

Yes	No

Who would help you if you became ill or injured?

Caregiver	Children	Friend	Spouse	None	Neighbors	Other family

Do you have smoke detectors?

Yes	No

Do you have safety bars in the bathroom?

Yes	No

Do you ever take your medications for reasons other than what they are prescribed for?

Yes	No

FALLS

How many times have you fallen in the past year and were you injured?

No falls in the past year	2 or more falls in the past year, but NO injury
1 fall in the past year, but NO injury	2 or more falls in the past year and injured
1 fall in the past year and injured	I do not walk

Do you feel unsteady or wobbly when standing or walking?	Yes	No
Do you worry about falling?	Yes	No
If recommended to use a cane or walker, do you use it consistently?	Yes	No

DIET

Are you generally able to eat well?	Yes	No

Which issues prevent you from eating well?

Problems chewing	Problems swallowing	Poor appetite	Illness	Financial reasons

Have you lost or gained weight without trying in the last year?	Yes	No

Do you consider your diet to be healthy?

Healthy	Portions Too Big	Too Much Sugar	Too Much Fat

EXERCISE

Do you participate in activities to increase your heart rate several days a week?	Yes	No
Do you participate in strength building activities at least twice per week?	Yes	No

As always, we thank you for allowing us to participate in all your healthcare needs.