Theresa Lerch, C-FNP, CNM   Lori Bowdler, FNP-BC   Caitlin Shea FNP-C
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Date_____________

Medicare Wellness Questionnaire

Health History Updates   Patient Name _________________________ DOB____________

Do you have a new preferred pharmacy? Yes______No______ if yes, where ________________
List below all health care providers you have seen in the past year
____
____

Home Vital Signs

Enter your current pain level ______ (0 equals no pain up to 10 equals worst pain)
If you check home blood pressure enter the average reading you get ______/______

Medication History Update

Have you stopped any medications since your last office visit here? Yes______No______
List any over the counter/supplements/herbs you take **at least once a week**
____
____

Family History Update

List below **any new diseases** in your parents or brother(s)/sister(s)
____
____

Surgical/Medical History Update

List below any major surgeries or hospitalizations you have had **within the past year**
____
____

Social History Update

Do you have a living will? Yes______No_______Do we have a copy? Yes______No_____
Do you have a medical power of attorney? Yes____No_____Do we have copy?Yes____No____
Do you smoke cigarettes? Yes______No______ If yes, how many packs per day ______

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Please check all that apply to you **Please initial** _____________

Diet

___ Healthy diet ___ less than 1 serving of fruit daily ___less than 1 serving of vegi daily
___high in starch/sugar (bread, pasta, crackers, baked goods, sugary drinks, etc.)
___high in salt ___high in fat ___low in calcium (dairy or calcium fortified foods)

Dental Health

___ not seen a dentist in greater than 12 months ___wear dentures ___**none apply to me**

Physical Activity

___exercise less than 2.5 hr. /week at moderate intensity (causes mild breathlessness)
___use cane, walker or wheelchair with activity ___ sitting lifestyle (sit more than 5 hrs. /day)
___**none apply to me**

Memory and Concentration

___trouble remembering recent events or conversations ___trouble solving problems
___trouble finding simple words or expressing thoughts
___trouble remembering directions to familiar places ___**none apply to me**

Speech/Motor difficulties

___problems with speaking ___trouble picking up very small objects
___trouble with writing/copying ___**none apply to me**

Hearing

___difficulty hearing over background noise ___off and on hearing loss
___loss of hearing in both ears ___loss of hearing in one ear only
___wears hearing aids ___has or had hearing aids but does not wear them
___require high volume on TV ___**none apply to me**

Vision

___blurred or abnormal vision ___blind spots in vision ___trouble seeing in bright light
___trouble seeing at night ___seeing double images with fatigue ___**none apply to me**

Activities of Daily Living (**mark any you are unable to do without assistance**)

___bathe ___dress ___eat ___groom ___toilet ___get out of chair/bed
___housework ___use the phone ___manage medications ___prepare meals
___manage money ___use public transportation ___grocery shop ___drive
___**none apply to me**

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Home Safety

___throw rugs not well secured on floor ___no handrail on stairs ___poor lighting in home
___no smoke/carbon dioxide detectors ___do not have hand bars in the bathroom/shower
___sunscreen not routinely used ___2 or more sexual partners in the last 6 months
___**none apply to me**

Vehicle Safety

___have been in a traffic accident in the past year ___do not wear helmet riding a bicycle
___do not wear a helmet riding a motorcycle ___do not wear seat belts in car all the time
___**none apply to me**

Pain Severity

___pain affects ability to do normal daily activities ___pain affects ability to sleep
___pain affects ability to do activites outside the home ___**none apply to me**

Pain Locations

___ frequent joint or muscle pain ___frequent abdominal pain _____frequent headaches
___**none apply to me**

Alcohol Misuse Screening

(1 serving=12 oz beer or 8 oz malt liquor or 5 oz wine or 1.5 oz hard liquor)
___during a typical week drink more than 7 servings of alcohol servings (females)
___during a typical week drink more than 14 servings (males) ___**none apply to me**

Depression Screening PHQ-2

Over the last 2 weeks how often have you been bothered by any of the following problems?

	not at all 0	Several days 1	More than half the days 2	nearly every day 3
Little interest or pleasure in doing things	___	___	___	___
Feeling down, depressed or hopeless	___	___	___	___

Fall Risk Assessment

___have fallen 1 time in the past year ___have fallen 2 or more times in the past year
___injury with a fall in the past year ___have a fear of falling ___you feel unsteady
___**none apply to me**

Patient Signature ____Date____________