Name:_______________________________ Date: _____________________

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Medicare Wellness

Medicare has now introduced an Annual Wellness Visit. This is a chance to develop and update a personalized prevention plan based on your current health and risk factors. This will include a few of the standard elements of a routine visit such as updating your medical history, family, history, update medications, specialists seen and vitals. This is NOT a physical and will not include an examination. The purpose of this visit is to go beyond what can be done in the context of a normal visit and focus on other elements important to your health. Factors Including: Home safety, your fall risk, the ability to achieve your activities of daily living, memory screening, depression, screening and end of life planning.

*Please complete packet before your appointment. If it is not completed by your appointment time, we will need to reschedule your appointment.

***If you have a living will please bring it to your appointment**.

Name:________________________________ Date: ______________________

HOME SAFETY CHECKLIST

Use this checklist to make sure that your home does not pose any health or safety hazards:

All Rooms:

- ○ No loose carpeting or rugs that do not have a non-slip backing.
- ○ Traffic areas free of furniture
- ○ Electrical cords and other wires taped against walls
- ○ Bright lighting with switches and all light bulbs in working order
- ○ Telephones placed on tables at height that can be reached from the floor.

Stairs and Inclines:

- ○ Does not Apply
- ○ Free of items
- ○ Plenty of room to move at top and bottom
- ○ No loose carpeting or edges to catch on
- ○ Handrails securely attached and at the proper height for user
- ○ Proper lighting on all steps, including switches at top and bottom

Bathrooms:

- ○ Grab bars near the tub, shower and toilet located and mounted properly
- ○ Non- slip surfaces in the tub or shower
- ○ Nightlight for when first entering the room
- ○ Rugs or bathmats with non-slip backing on the floor
- ○ Shower/tub bench or seat

Bedrooms:

- ○ Bedside table with non-tip lamp and room for eyeglasses
- ○ Clear traffic area from bedroom to bathroom
- ○ Comfortable, sturdy chair to aid in dressing

Kitchen:

- ○ Items placed where they can be reached without the use of a stool
- ○ Area to sit during food preparation
- ○ Flooring free of cracks, splits or up-turned edges

Name:________________________________ Date: ______________________

CHECKLIST OF ACTIVITIES OF DAILY LIVING (ADL)

Check the level of function of each activity listed below. This will help us determine your functional status and how much assistance you may need.

FUNCTION:	INDEPENDENT	NEEDS HELP	DEPENDENT	CANNOT DO
Bathing:				
Dressing:				
Grooming:				
Oral Care:				
Toileting:				
Transferring bed/chair:				
Walking				
Climbing stairs				
Eating				
Shopping				
Cooking				
Managing Medication				
Using the phone				
Housework				
Doing Laundry				
Driving				
Managing Finances				

Name:________________________________ Date: ______________________

HEARING INVENTORY- SCREENING VERSION

Answer each question by checking the appropriate box “YES”, “NO” or “SOMETIMES”

1. Does your hearing cause you to feel embarrassed when meeting new people?

   ☐ Yes ☐ No ☐ Sometimes

2. Does your hearing cause you to feel frustrated when talking to members of your family?

   ☐ Yes ☐ No ☐ Sometimes

3. Do you have difficulty hearing when someone speaks in a whisper?

   ☐ Yes ☐ No ☐ Sometimes

4. Do you feel held back by a hearing problem?

   ☐ Yes ☐ No ☐ Sometimes

5. Does your hearing cause you difficulty when visiting friends, relatives or neighbors?

   ☐ Yes ☐ No ☐ Sometimes

6. Does your hearing cause you to have arguments with family members?

   ☐ Yes ☐ No ☐ Sometimes

7. Does your hearing cause you difficulty when listening to TV or radio?

   ☐ Yes ☐ No ☐ Sometimes

8. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?

   ☐ Yes ☐ No ☐ Sometimes

9. Does you hearing cause you difficulty when in a restaurant with relatives or friends?

   ☐ Yes ☐ No ☐ Sometimes

Name:______________________________ Date: ____________________

HEARING SCREEINING QUESTIONNAIRE

This portion is to be completed by a friend or your significant other it is not that we do not trust you but sometimes it is nice to get a third-party objective opinion.

1. Have you ever noticed that your significant other has had deafness or trouble hearing with one or both ears?

☐ Yes ☐ No

If yes, was this evaluated? Where?

2. Without a hearing aid, can your significant other usually hear and understand what a person says without seeing his/her face if that person whispers to them from across the room?

☐ Yes ☐ No ☐ Sometimes

3. Without a hearing aid, can your significant other usually hear and understand what a person says without seeing his/her face if that person talks in a normal voice to them from across the room?

☐ Yes ☐ No ☐ Sometimes

Please sign below and state your relationship to the patient

______________________ ______________________

Signature Relationship

Name:_______________________________ Date: _____________________

Why is pre-planning for end of life decisions important?

It is not pleasant to think of not being able to make your own decisions. Imagine being so sick that you cannot communicate your wishes and desires such as seen with Terry Shivo. Even just riding in a car can lead to an unfortunate accident with serious medical injuries, it does not matter how old you are. One can never plan something like this.

What we can do is plan who will make decisions for you if you cannot make them for yourself. That is what the technical term surrogate decision maker refers to. This person will not make any medical decisions for you unless you are unable to make the decisions yourself. Think of them as a safety net. You hope you never need it but just in case it is a good thing to have.

We ask you to think of someone who knows you well, cares for you, is able to make difficult decisions, and will be able to communicate your wishes. Your spouse may be the person that knows you best but keep in mind that they are also the most likely to be riding with you in a car if you get in an accident and neither of you may be in any shape to make decisions. Just brainstorm between your friends and family members and see who you feel most confident with in this decision-making role.

You can retract this at any time by updating the surrogate decision maker form. This form is also available on our website for download just make sure you notify our office so we can update your chart.

To help your surrogate decision maker know what you would want in certain situations we ask that you have an open discussion with them. This will provide you decision maker insight into some scenarios for which you can identify your wishes.

You can complete the following pages but please do not sign and date them until your appointment so our staff can serve as a witness.

Some additional resources for information are:

Five Wishes: http://www.agingwithdignity.org/five-wishes.php

Hospice: http://www.hospicefoundation.org/

Name:______________________________ Date: ____________________

Regarding the use of life-sustaining procedures (e.g assistance with respiration, mechanical means to maintain blood pressure and heart rate, and tube feeding):

If I were gravely impaired by Alzheimer's Disease?

☐ Use ☐ Do not use ☐ Only if my doctor believes it could help

If my brains thinking functions were severely damaged?

☐ Use ☐ Do not use ☐ Only if my doctor believes it could help

If I am in a coma from which I am not expected to wake up?

☐ Use ☐ Do not use ☐ Only if my doctor believes it could help

If I would recover sufficiently to be comfortable and active?

☐ Use ☐ Do not use ☐ Only if my doctor believes it could help

If I were near death with a terminal illness?

☐ Use ☐ Do not use ☐ Only if my doctor believes it could help

List below any other condition under which you believe that the burdens of life-support treatment are too much and not worth the benefits and therefore do not wish to have life- support treatment:

Name:______________________________ Date:________________________

Signature:___________________________ Witness:_______________________

Name:_________________________________ Date: ______________________

Medicare wellness check-up

Please complete this checklist before seeing your doctor or nurse. Your response will help you receive the best care possible.

1. 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

2. 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

3. During the past four weeks, how much bodily pain have you generally had?

- ○ No Pain
- ○ Very mild pain
- ○ Moderate pain
- ○ Sever pain

4. 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 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

5. 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

6. Can you get to places out of walking distance without help? (for example, can you travel alone on buses or taxis, or drive your own car?)

- ○ Yes
- ○ No

7. Can you go shopping for groceries or clothes without someone's help?

- ○ Yes
- ○ No

8.Can you prepare your own meals?

- ○ Yes
- ○ No

9. Can you do your housework without help?

- ○ Yes
- ○ No

10. Because of any health problems, do you need the help of another person with you personal care needs such as eating, bathing, dressing, or getting around the house?

- ○ Yes
- ○ No

Name:________________________________ Date: ______________________

11. Can you handle your own money without help?

- ○ Yes
- ○ No

12. During the past four weeks, how would you rate your health in general?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

13. How have things been going for you during the past 4 weeks?

- ○ Very well; could hardly be better
- ○ Pretty well
- ○ Good and bad parts about equal
- ○ Pretty bad
- ○ Very bad, could hardly be worse

14. Are you having difficulties driving your car?

- ○ Yes, often
- ○ Sometimes
- ○ No
- ○ Not applicable, I do not use a car

15. Do you always fasten your seat belt when you are in a car?

- ○ Yes, usually
- ○ Yes, sometimes
- ○ No

16. Are you a smoker?

- ○ No
- ○ Yes, and I might quit
- ○ Yes, but I'm not ready to quit

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

Falling or dizzy when standing up:

_Never _Seldom _ Sometimes _Often _Always

Sexual Problems:

_Never _Seldom _ Sometimes _Often _Always

Trouble eating well:

_Never _Seldom _ Sometimes _Often _Always

Teeth or denture problems:

_Never _Seldom _ Sometimes _Often _Always

Problem using the telephone:

_Never _Seldom _Sometimes _Often _Always

Tiredness or fatigue:

_Never _Seldom _ Sometimes _Often _Always

18. Have you fallen two or more times in the past year?

- ○ Yes
- ○ No

19. Are you afraid of falling?

- ○ Yes
- ○ No

20. 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

Name:_______________________________ Date: _____________________

21. 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

22. 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 medication?

- ○ Yes
- ○ No

23. How often do you have trouble taking medicines the way you have been told to take them?

- ○ I do not have to take medicine
- ○ I always take them as prescribed
- ○ Sometimes I take them as prescribed
- ○ I seldom take the as prescribed

24. 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

25. 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

Thank you very much for completing your Medicare wellness Checkup. Please give the completed check up to the doctor or nurse at your appointment.

Name:________________________________ Date: ______________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more that usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

- - - - - - - - - - - -**Doctor Use Only** - - - - - - - - - - - -

Add columns ______ + ______ + ______

Total:______

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?	___: Not difficult at all ___: Somewhat difficult ___: Very difficult ___: Extremely difficult

Name:_______________________________ Date: _____________________

The Alcohol Use Disorders Identification Test: Self- Report Version					
Patient: Because alcohol use can affect your health and can interfere with certain medication and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in on box that best describes your answer to each question.					
Questions	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink of alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2.How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8.How often during the last year have you been unable to remember what happened the night before because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
Total:					