

Patient Name _____
Patient DOB _____
Today's Date: _____

**Annual Medicare Wellness Questionnaire**

Please complete this checklist before seeing your provider. Your responses will help you receive the best healthcare possible.

1. What is your age?

65-69  70-79  80 or Older

2. Are you Male or Female?  Male  Female

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.

16. Are you having difficulties driving your car?

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

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 alone on buses or 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 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.

23. Do you exercise for about 20 minutes three or more times per week?

- Yes, most of the time.
- Yes, some of the time.
- No, I usually do not exercise this much.

17. Do you always fasten your seat belt when you are in a care?

- Yes, usually.  
 Yes, sometimes.  
 No.

18. How often during 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

**Problems using the telephone.**

Never  Seldom  Sometimes  Often  Always

**Tiredness or fatigue.**

Never  Seldom  Sometimes  Often  Always

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

- Yes  No

20. Are you afraid of falling?

- Yes  No

21. Are you a smoker?

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

22. During the past four weeks, how many drinks of wine, beer, or alcoholic beverages did you have?

- 10 or more drinks per week.  
 6-9 drinks per week.  
 2-5 drinks week.  
 One drink or less per week.  
 No alcohol at all.

24. 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

25. How often do you have trouble taking medications 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 them as prescribed.

26. How confident are you that you can control and manage most of your health problems?

- Very confident.  
 Someone confident.  
 Not very confident.  
 I do not have any health problems.

27. 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 form to your provider or nurse.***

8/2/17

**BW PRIMARYCARE**  
*Bridge to Wellness*

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Depression Screening Test PHQ - 9**  
**PHQ 9**

*Over the past 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 asleep, 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're 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 slowly that other people could have noticed. Or, the opposite- being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

Add Columns      +      +      =

( Healthcare professional: For interpretation of TOTAL, please refer to scoring card)

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