WELLNESS CHECKUP

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

Your name: _____

Today's date: _____

Your date of birth: _____

1. What is your age?
   ☐ 18-64 ☐ 65-69 ☐ 70-79 ☐ 80 or older
2. Are you a male or a 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.
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 your 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.

continued ➤

AAFP FPM

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

 Related article: https://www.aafp.org/fpm/2012/0300/p11.html.

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.

16. Are you having difficulties driving your car?

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

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

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

18. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.	☐	☐	☐	☐	☐
Sexual problems.	☐	☐	☐	☐	☐
Trouble eating well.	☐	☐	☐	☐	☐
Teeth or denture problems.	☐	☐	☐	☐	☐
Problems using the telephone.	☐	☐	☐	☐	☐
Tiredness or fatigue.	☐	☐	☐	☐	☐

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 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.

23. 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.

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 medications?

☐ Yes ☐ No.

25. 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 them as prescribed.

26. 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.

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 checkup to your doctor or nurse.