Choice Medical Walk-In Family Practice
Phone: 623.434.5748 Online: www.choicemedicalwalkin.com
Anthem Office - 3624 W. Anthem Way, Suite C-122, Anthem, AZ 85086
Peoria Office - 9947 W. Happy Valley Parkway, Suite 104, Peoria, AZ 85383

MEDICARE WELLNESS QUESTIONNAIRE

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health care possible.
(Use "✓" to indicate your answer)

1. What is your age?
   - ☐ 65-69
   - ☐ 70-79
   - ☐ 80 or older

2. Are you a 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? ***(If Moderate, Quite a bit, or Extremely, patient needs to complete Patient Health Questionnaire)***
   - ☐ 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? ***(If Moderate, Quite a bit, or Extremely, patient needs to complete Patient Health Questionnaire)***
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

5. During the **past four weeks**, how much bodily pains have you generally had? ***(If Moderate or Severe, patient needs to complete Patient Health Questionnaire)***
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderately 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 someone's 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? ***(If Fair or Poor, patient needs to complete Nutritional Assessment)***
    - ☐ 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

16. Are you having difficulties driving the 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 phone	☐	☐	☐	☐	☐
Tiredness or fatigue	☐	☐	☐	☐	☐

19. Have you fallen two or more times in the past year? ***(If Yes, patient will need to complete Fall Prevention Home Assessment)***
    - ☐ Yes
    - ☐ No

20. Are you afraid of falling? ***(If Yes, patient will need to complete Fall Prevention Home Assessment)***
    - ☐ Yes
    - ☐ No

21. Are you a smoker? ***(If Yes, patient will need to complete Smoker's Home Assessment)***
    - ☐ No
    - ☐ Yes, and I might quit
    - ☐ Yes, but I am 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 or less per week
    - ☐ No alcohol at all

23. Do you exercise for about 20 minutes three or more day 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 medication?
- ☐ 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

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PATIENT HEALTH QUESTIONNAIRE

Over the past 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
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 than usual	☐ 0	☐ 1	☐ 2	☐ 3
Thoughts that you would be better off dead, or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

ADD COLLUMNS: ☐ + ☐ + ☐

(Healthcare Professional: For interpretation of TOTAL, please refer to score card) TOTAL: ☐

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
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 other people?	☐	☐	☐	☐

NUTRITIONAL ASSESSMENT

(Use "✓" to indicate your answer)

	YES	NO
I have an illness or condition that has made me change the kind and/or amount of food I eat	☐ 2	☐ 0
I eat fewer than two meals a day	☐ 3	☐ 0
I eat few fruits, vegetables, or milk products	☐ 2	☐ 0
I have three or more drinks of beer, liquor or wine almost every day	☐ 2	☐ 0
I have tooth or mouth problems that make it hard for me to eat	☐ 2	☐ 0
I do not always have enough money to buy the food I need	☐ 4	☐ 0
I eat alone most of the time	☐ 1	☐ 0
I take three or more different prescribed or over-the-counter drugs a day	☐ 1	☐ 0
Without wanting to, I have lost or gained 10 pounds in the past six months	☐ 2	☐ 0
I am not always physically able to shop, cook and/or fee myself	☐ 2	☐ 0

The scale above is scored as follows:

0-2 = Good nutrition. Recheck nutritional score in 6 months.
3-5 = Moderate nutritional risk. Improve eating habits and lifestyle. Recheck nutritional score in 3 months.
6 or more = High nutritional risk. Recommend intervention.

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FALL PREVENTION HOME ASSESMENT

Any "NO" Answers Indicates a Need for Improvement

BATHROOM	YES	NO
1. Is the path from the bedroom to the bathroom well lit?	☐	☐
2. Are there grab bars near the toilet and in the shower and bathtub?	☐	☐
3. If you have difficulty standing in the shower, do you use a shower seat?	☐	☐
4. Are spills cleaned up immediately?	☐	☐
5. Do your bathmats have slip-resistant backing?	☐	☐
6. Do you remove soap build in your shower/bathtub up to avoid slipping?	☐	☐
7. Can you reach soap in the shower without bending down or turning too far around?	☐	☐
8. Do you have a raised toilet seat of you have difficulty standing up and sitting down?	☐	☐

KITCHEN	YES	NO
1. Are throw rugs/floor mats secure?	☐	☐
2. Can you get to regularly used items without bending down or reaching up too far?	☐	☐
3. Are spills cleaned up immediately?	☐	☐
4. Is food prepared at the kitchen table?	☐	☐

PORCH, YARD, OUTSIDE	YES	NO
1. Is the path from the house to the garage well lit?	☐	☐
2. Are there cracks or buckles on the sidewalks or driveway?	☐	☐
3. Are there hoses, weeds or other obstacles on the walkways?	☐	☐
4. Are there icy steps or walkways?	☐	☐

BEDROOM	YES	NO
1. Is there a table close to your bed with a lamp and room to store eyeglasses and a phone?	☐	☐
2. Are cords pushed back against the wall?	☐	☐
3. Is there clutter on the floor?	☐	☐

LIVING AREAS	YES	NO
1. Are floor coverings secure and sturdy?	☐	☐
2. Can you answer the phone without getting up?	☐	☐
3. Are cords pushed back against the wall?	☐	☐
4. Can you turn on a light without having to walk into a dark room?	☐	☐
5. Do you have a step stool that has side rails, sturdy and in good condition?	☐	☐
6. Do you have a cordless or cellular phone or an emergency alarm device?	☐	☐
7. Is your floor free of clutter?	☐	☐
8. Is it easy to walk around the furniture in your home?	☐	☐
9. Can you pull cords to lights or ceiling fans without reaching up?	☐	☐
10. Are there handrails on both sides of the stairways in your home?	☐	☐
11. Are the steps on your stairways even and safe?	☐	☐
12. Are there lights at the top and bottom of the stairs?	☐	☐

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SMOKER'S HOME ASSESSMENT

(Use "✓" to indicate your answer)

	YES	NO
Do you have working smoke detectors in your home/apartment?	☐	☐
Do you regularly change the batteries in your smoke detectors?	☐	☐
If you have space heaters, are they far away from flammable objects?	☐	☐
Do you have a fire extinguisher accessible in your house/apartment?	☐	☐
Do you have a fire exit plan?	☐	☐
Do you have a working flashlight available for power outages?	☐	☐