Medicare Wellness Checkup **Your Name:_____**

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

Today's Date: _____

Your Date of Birth:_____/_____/_____

1. **What is your occupation? _____**
2. **What type of diet do you eat?**
   a. **Regular** b. **Diabetic** c. **Low sodium** d. **Low Fat**
   e. **Low carbohydrate** f. **Low fiber**
3. **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 you.)**
   a. **Yes, as much as I wanted** b. **Yes, quite a bit** c. **Yes, some**
   d. **Yes, a little** e. **No, not at all**
4. **Do you need help with transportation?** ☐ **Yes** ☐ **No**
5. **Can you go shopping for groceries or clothes without someone's help?**
   ☐ **Yes** ☐ **No**
6. **Can you prepare your own meals?** ☐ **Yes** ☐ **No**
7. **Can you do your own house work without help?** ☐ **Yes** ☐ **No**
8. **Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, laundry, dressing or getting around the house?** ☐ **Yes** ☐ **No**
9. **Can you handle your own money without help?** ☐ **Yes** ☐ **No**
10. **During the past four weeks, how would you rate your health in general?**
    a. **Excellent** b. **Very good** c. **Good** d. **Fair** e. **Poor**
11. **Are you a smoker?** ☐ **Yes** ☐ **No**

12. During the past four week, how many drinks of beer, wine, or other alcoholic beverages did you have?

a. 10 or more per week **b. 6-9 per week** **c. 2-5 per week**

c. One or less per week **d. no alcohol at all**

13. Do you exercise for more than 20 minutes three or more days a week?

a. Yes, most of the time **b. Yes, some of the time**

c. No, I usually do not exercise this much

14. What is your race? (Circle all that apply) **a. White** **b. Black or African American**

c. Asian **d. Native Hawaiian or other Pacific Islander**

e. American Indian/Alaskan Native **f. Hispanic or Latino origin or descendant**

g. Other

15. Do you feel like you are safe in your home? ☐ **Yes** ☐ **No**

16. Do you need help with the phone? ☐ **Yes** ☐ **No**

17. Do you need help managing your medications? ☐ **Yes** ☐ **No**

18. Do you have difficulty driving? ☐ **Yes** ☐ **No**

19. Does your home have poor lighting? ☐ **Yes** ☐ **No**

20. Does your home have stairs? ☐ **Yes** ☐ **No**

21. Does your staircase have handrails ☐ **Yes** ☐ **No**

22. Does your bathroom have grab bars ☐ **Yes** ☐ **No**

23. Do you have throw rugs or runners in your home? ☐ **Yes** ☐ **No**

24. Does your home have a functioning smoke alarm? ☐ **Yes** ☐ **No**

25. Have you noticed any hearing difficulties? ☐ **Yes** ☐ **No**

To help determine if you are at significant risk for a fall or have a balance disorder, take the Balance Self-Test below. If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he/she may help determine the cause of your symptoms.

FALL PREVENTION BALANCE & DIZZINESS SURVEY

PATIENT NAME:_____ **DATE:**_____

DATE OF BIRTH:_____/_____/_____

Please complete survey and sign at the bottom. If it's determined that you are at risk for a fall, a balance assessment will be performed.

Please read each question and check the box that most describes your answer	YES	SOME-TIMES	NO
1. Have you had a recent loss of or decrease in your vision or hearing?			
2. Have you fallen 2 or more times in the past year, fallen and had an injury , or fallen without an obvious reason?			
3. Do you fear falling?			
4. Does moving your head quickly make you dizzy or cause you to feel nauseous?			
5.0 Does dizziness or imbalance interfere with your job or your household responsibilities?			
6. Do you use a walker, cane, or any other form of assistance for your mobility?			
7. Are you ever dizzy or unsteady when you first get up in the morning?			
8. DO you ever fall or feel like you are about to fall for no apparent reason?			
9. Does walking down the aisle of a supermarket or stopping next to moving traffic make you dizzy?			
10. Do you feel dizzy while sitting down or rising from a seated or lying position?			
11. Do you feel unsteady when you are walking or climbing stairs?			
12. DO you ever lose your balance or feel dizzy or unsteady?			
13. Has your balance problem caused problems in your social life?			
14. Have you continued to experience dizziness after an injury or accident?			
15. Have you experienced dizziness, vertigo, or serious imbalance in the past six months?			

Signature:_____ **Phone Number:**_____