NORTHWEST ALLIED PHYSICIANS

Today's Date:	Medical Record Number:
Patient Name:	Date of Birth:

Please check if you have one of the following as your primary insurance:

☐ UHC ☐ BCBS ☐ Humana ☐ Aetna ☐ Care More ☐ Health Choice ☐ Care First

Medicare Wellness Questionnaire

✓ *Place a check mark by all that apply to you*

Diet

☐Healthy diet (well balanced)
☐Low calcium intake
☐ Low salt intake
☐Diet is high in salt
☐High carbohydrate meals (starchy food/sugary drinks)
☐ Low fat intake
☐High calorie diet
☐Caffeine Intake _____ (cups per day)

Fracture Risk

☐ History of fractures
☐ Recent sudden unexplained fractures
☐ Recent explained fracture (known trauma like a fall)
☐ Previous major muscle or joint injuries

Physical Activity

☐ Does not exercise on a regular basis
☐ Decreased physical activity
☐ Poor Physical condition
☐ Out of shape due to sedentary (sitting a lot) lifestyle

☐ Physically active/ regular exercise
- Average minutes per day of physical activity _____

If you are physically active please answer the following questions:
- Days per week of physical activity _____
- Type of physical activity_____

Depression Risk

☐ Feel sad, empty, or tearful
☐ Trouble getting enough sleep
☐ Thoughts of suicide
☐ Feeling worthlessness or guilt
☐ Loss of interest in activities
☐ Irritable mood
☐ History of depression
☐ Significant changes in weight
☐ Loss of energy
☐ History of mood disorders

Memory and Concentration

☐ Decreased concentration
☐ Memory lapses or loss
☐ Forgetting words

Speech/Motor Difficulties

☐ Speech Difficulties
☐ Difficulty writing/copying
☐ Difficulty expressing ideas
☐ Knocking things over when trying to pick them up
☐ Difficulty with fine movements of hand
☐ Slowed reaction time

Hearing

☐Loss of hearing in one ear only
☐Getting progressively worse
☐Tone deafness
☐Loss of hearing in both ears
☐Difficulty hearing over background noise
☐Fluctuating
☐Requires TV, radio at high volume

Vision

☐Total vision loss
☐Worse with distance
☐Seeing double images with fatigue
☐Increased sensitivity to glare
☐Worsening
☐Worse both distance and near
☐Blind spot(s)
☐Difficulty seeing in bright light
☐Blurred vision
☐Episodes of brief vision loss
☐Worse near
☐Sudden partial vision loss
☐Worsening depth perception

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Activities of Daily Living

- ☐ Unable to bathe without assistance
- ☐ Unable to dress without assistance
- ☐ Unable to control urination and bowels
- ☐ Unable to feed self without assistance
- ☐ Unable to get out of a chair or bed without assistance
- ☐ Unable to groom without assistance
- ☐ Unable to toilet without assistance

Instrumental Activities of Daily Living

- ☐ Unable to do housework without assistance
- ☐ Unable to grocery shop without assistance
- ☐ Unable to manage medication without assistance
- ☐ Unable to manage money without assistance
- ☐ Unable to prepare meals without assistance
- ☐ Unable to use a phone without assistance

Fall Risk Assessment

- ☐ Fall(s) in the past month ____
- ☐ Fall(s) in the past year _____
- ☐ Frequent falls while walking
- ☐ Frequent dizziness
- ☐ Fear of falling
- ☐ Injury with fall

Home Safety

- ☐ Unsafe stairs
- ☐ Unsafe flooring hazards (throw rugs)
- ☐ No smoke / CO detectors
- ☐ Does not wear helmet for biking
- ☐ Does not use seatbelts
- ☐ Has experienced vision or hearing loss while driving
- ☐ Number of motor vehicle accidents _____
- ☐ Does not have hand bars in the bathroom/shower
- ☐ Poor lighting in the home

Pain Assessment

- ☐Frequent chest pain
- ☐Frequent abdominal pain
- ☐ Moderate severity joint/muscle pain

Health History Update

List below any major surgeries or hospitalizations you have had within the past (1) year.

List below any new diseases in your parent(s) or brother(s)/sister(s)

Do you currently smoke cigarettes: ☐Yes ☐No

Do you have a living will: ☐Yes ☐No

Do you have a medical power of attorney: ☐Yes ☐No

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Medicare Wellness Questionnaire ✓ ***Place a check mark by all that apply to you***	

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day? ☐ None

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Medicare History:

Please fill in blank with date of most recent completion for each study/vaccine.

Women:

1. Last Pap smear _____
2. Last Mammogram _____
3. Colonoscopy_____
4. Bone Density Screening_____
5. Flu vaccine_____
6. Pneumonia vaccine _____
7. Shingles vaccine_____
8. Tetanus vaccine_____

Men:

1. Last PSA_____
2. Colonoscopy_____
3. Flu vaccine_____
4. Pneumonia vaccine _____
5. Shingles vaccine_____

List below all health care providers you have seen at least once in the past (1) year.

_____
_____
_____
_____
_____

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Medicare Wellness Questionnaire	

Patient Health Questionnaire –9
(PHQ-9)
Please answer the following questions honestly and to the best of your ability:

Over the last 2 weeks how often have you been bothered by any of the following problems?
Please circle your answer

	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 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 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

For office coding _____ + _____ + _____ + _____

= Total score_____

If you circled any problems, how difficult have those problems made it for you to do you work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

_____ Physician's Signature

_____ Date

_____ Time