|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| OHSU_H_4C_POS_RGB.jpg |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Name: |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Date: |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | DOB: |  |  |  |  |  |  |  |  |  |  |  |  |
| **Medicare Wellness Visit** | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Please complete this form before seeing your provider. Your responses will help you receive the best health care possible. | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Do you smoke?** | | |  | **What is your race?** (Check all that apply) | | | | |  |  |  |  |  |  |  |  |
| □ | No |  |  | □ | White | | | |  |  |  |  |  |  |  |  |
| □ | Yes, but I might quit | | | □ | Black or African American | | | |  |  |  |  |  |  |  |  |
| □ | Yes, but I'm not ready to quit | |  | □ | Asian | | | |  |  |  |  |  |  |  |  |
|  |  | □ | Native Hawaiian or other Pacific Islander | | | |  |  |  |  |  |  |  |  |
|  |  |  |  | □ | Native American or Alaskan Native | | | |  |  |  |  |  |  |  |  |
| **Are you:** |  |  |  | □ | Hispanic or Latino origin or decent | | | |  |  |  |  |  |  |  |  |
|  | □ Male | □ Female |  | □ | Other | | | |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Looking back over the past FOUR weeks, how would you rate your health in general?** | | |  | **Looking back over the past FOUR weeks, what was the hardest physical activity you could do for at least two minutes?** | | | | |  |  |  |  |  |  |  |  |
| □ | Excellent |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| □ | Very good |  |  | □ | Very heavy | |  |  |  |  |  |  |  |  |  |  |
| □ | Good |  |  | □ | Heavy | |  |  |  |  |  |  |  |  |  |  |
| □ | Fair |  |  | □ | Moderate | |  |  |  |  |  |  |  |  |  |  |
| □ | Poor |  |  | □ | Light | |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | □ | Very Light | |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **DRIVING** | | | | | | | | |  |  |  |  |  |  |  |  |
| Do you drive? | □ Yes | □ No |  | Do you wear a seatbelt? | | | □ Yes | □ No |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Do you limit your driving in any way? | | |  |  |  |  | □ Yes | □ No |  |  |  |  |  |  |  |  |
| If yes, describe: | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| In the past 2 years, have you had any accidents or citations? | | | | |  |  | □ Yes | □ No |  |  |  |  |  |  |  |  |
| If yes, describe: | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Has anyone ever been concerned about your driving? | | | | |  |  | □ Yes | □ No |  |  |  |  |  |  |  |  |
| If yes, describe: | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **In the past FOUR weeks, have you….?** | | | | | | | | |  |  |  |  |  |  |  |  |
|  | **Never** | **Seldom** | **Sometimes** | **Often** | **Always** | **Comments** | | |  |  |  |  |  |  |  |  |
| **Exercised at least 20min, 3 or more days/week** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Consume 5 servings of fruits & vegetables daily** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Had pain that limited your activities?** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| Label goes here |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **In the past FOUR weeks, have you experienced any of the following?** | | | | | | | | |  |  |  |  |  |  |  |  |
|  | **Never** | **Seldom** | **Sometimes** | **Often** | **Always** | **Comments** | | |  |  |  |  |  |  |  |  |
| **Physical health limited your activities** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Tiredness or fatigue** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Memory problems** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Lonely** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Stressed** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Angry** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Isolated** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Teeth or denture problems** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Sexual problems** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Trouble hearing** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Wear a hearing aid** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **In the past FOUR weeks, have you had difficulty with any of the following tasks?** | | | | | | | | |  |  |  |  |  |  |  |  |
| **Task** | **No Difficulty** | **Some Difficulty** | **Very Difficult** | **Do you need help with this task?** | **Do you have help with this task?** | **Is your family concerned about you performing this task?** | | |  |  |  |  |  |  |  |  |
| **Walk across a room (including using a cane or walker)** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Standing up or sitting down** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Going up or down stairs** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Getting Dressed** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Bathing or Showering** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Feeding yourself** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Using the toilet** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Using the phone** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Manage medications** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Prepare meals** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Pay bills** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Housecleaning** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Laundry** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Grocery shopping** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Driving** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Using public transportation** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |
| **Using computer** |  |  |  |  |  |  | | |  |  |  |  |  |  |  |  |