Name: _____ Date: _____ Date of Birth: _____

A Checklist for Your Medicare Wellness Annual Visit

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

1. During the past 4 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

2. During the past 4 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

3. During the past 4 weeks, how much bodily pain have you generally had?
   - ☐ No Pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe Pain

4. During the past 4 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

5. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
   - ☐ Very heavy
   - ☐ Heavy
   - ☐ Moderate
   - ☐ Light
   - ☐ Very Light

	Yes	No
6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?		
7. Can you shop for groceries or clothes without help?		
8. Can you prepare your own meals?		
9. Can you do your own housework without help?		
10. Can you handle your own money without help?		
11. Do you need help eating, bathing, dressing, or getting around your home?		

12. During the past 4 weeks, how would you rate your health in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

13. How have things been going for you during the past 4 weeks?
   - ☐ Very well- could hardly be better
   - ☐ Pretty good
   - ☐ Good and bad parts about equal
   - ☐ Pretty bad
   - ☐ Very bad- could hardly be worse

14. Are you having difficulties driving your car?

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

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

☐ Yes, usually
☐ Yes, sometimes
☐ No

16. How often during the past 4 weeks, have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up					
Sexual problems					
Trouble eating well					
Teeth or dentures					
Problems using the telephone					
Tired or fatigued					

17. Do you currently smoke?

☐ No
☐ Yes, and I might quit
☐ Yes, but I'm not ready to quit

18. During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have?

☐ 10 or more per week
☐ 6-9 per week
☐ 2-5 per week
☐ 1 drink or less per week
☐ No alcohol at all

19. Do you exercise for about 20 minutes 3 or more days a week?

☐ Yes, most of the time
☐ Yes, some of the time
☐ No, I usually do not exercise this much

20. 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

21. 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

22. In the past 6 months, have you experienced leaking of urine?

☐ Yes
☐ No

23. How much did leaking of urine make you change your daily activities or interfere with your sleep?

☐ Very little time
☐ Some of the time
☐ All of the time

	Yes	No
24. Do you live alone? If No, who lives with you?_____		
25. Do you have throw rugs in your home?		
26. Does your home have poor lighting?		
27. Do you have grab bars in your bathroom?		
28. Do you have handrails on stairs and steps in your home?		
29. Does your home have functioning smoke alarms?		
30. Have you fallen 2 or more time in the past year?		
31. Are you afraid of falling?		
32. Do you feel unsteady when walking?		

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

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

PHQ-9	**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 your 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
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

OakLeaf CLINICS

Name: _____

DOB: _____

Social determinants of health are circumstances in the areas where our patients live, work, and play that affect a wide range of health and quality of life health outcomes. We are collecting this voluntary self-reported information to better serve our patients.

SOCIAL DETERMINANTS

FINANCIAL RESOURCE STRAIN:

How hard is it for you to afford the very basics like food, housing, and medical care? *Check one.*

☐ Very hard ☐ Hard ☐ Somewhat hard ☐ Not very hard ☐ Not hard at all ☐ Refuse to answer

TRANSPORTATION NEEDS:

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medication? *Check one.*

☐ Yes ☐ No ☐ Refuse to answer

In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living? *Check one.*

☐ Yes ☐ No ☐ Refuse to answer

STRESS:

Do you feel stress these days– tense, restless, nervous, anxious, unable to sleep at night because your mind is troubled all the time? *Check one.*

☐ Not at all ☐ Only a little ☐ To some extent ☐ Rather much ☐ Very much ☐ Refuse to answer

INTIMATE PARTNER VIOLENCE:

Within the last year, have you been afraid of your partner or ex-partner? *Check one.*

☐ Yes ☐ No ☐ Refuse to answer

Within the last year, have you been emotionally abused in other ways by your partner or ex-partner? *Check one.*

☐ Yes ☐ No ☐ Refuse to answer

Within the last year, have you been hit, kicked, slapped, or otherwise physically hurt by your partner or ex-partner? *Check one.*

☐ Yes ☐ No ☐ Refuse to answer

Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? *Check one.*

☐ Yes ☐ No ☐ Refuse to answer

HOUSING STABILITY:

In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time? *Check one.*

☐ Yes ☐ No ☐ Refuse to answer

In the last 12 months, how many places have you lived?

In the last 12 months, was there a time when you did not have a steady place to sleep, or slept in a shelter (including now)? *Check one.*

☐ Yes ☐ No ☐ Refuse to answer

FOOD INSECURITY:					
Within the past 12 months, you worried that your food would run out before you got money to buy more. *Check one.*					
☐ Never true	☐ Somewhat true	☐ Often true	☐ Refuse to answer		
Within the past 12 months, the food you bought just did not last and you didn't have money to buy more. *Check one.*					
☐ Never true	☐ Somewhat true	☐ Often true	☐ Refuse to answer		
PHYSICAL ACTIVITY:					
On average, how many days per week do you engaged in moderate to strenuous exercise that cause a light or heavy sweat (walking fast, running, swimming, dancing, biking)?					
On average, how many minutes do you engage in exercise at this level?					
SOCIAL CONNECTIONS:					
In a typical week, how many times do you talk on the phone with family, friends, neighbors? *Check one.*					
☐ Never	☐ Once a week	☐ Twice a week	☐ Three times a week	☐ More than three times	☐ Refuse to answer
How often do you get together with friends or relatives? *Check one.*					
☐ Never	☐ Once a week	☐ Twice a week	☐ Three times a week	☐ More than three times	☐ Refuse to answer
How often do you attend church or religious services? *Check one.*					
☐ Never	☐ 1-4 times per year	☐ More than 4 times per year	☐ Refuse to answer		
Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups? *Check one.*					
☐ Yes	☐ No	☐ Refuse to answer			
If yes, how often do you attend meetings of the clubs or organizations you belong to? *Check one.*					
☐ Never	☐ 1-4 times per year	☐ More than 4 times per year	☐ Refuse to answer		
Are you married, widowed, divorced, separated, never married, or living with a partner?					
☐ Married	☐ Widowed	☐ Divorced	☐ Separated	☐ Never married	☐ Living with partner	☐ Patient refused