MEDICARE WELLNESS PRE-VISIT QUESTIONNAIRE

Name: _____ Date of Birth: _____

Please list below other providers you see for your medical care:

	Provider Name	Provider Specialty
1		
2		
3		
4		
5		
6		
7		
8		
9		

Please circle your answers to the questions below:

HEARING LOSS SCREEN

1. Do you have trouble hearing the television or radio when others do not? Yes or No
2. Do you strain or struggle to hear/understand conversations? Yes or No

FUNCTIONAL SCREEN

1. Do you live alone? Yes or No
2. Do you need help with preparing meals? Yes or No
3. Do you need help with transportation? Yes or No
4. Do you need help with shopping? Yes or No
5. Do you need help with taking your medications as prescribed? Yes or No
6. Do you need help with managing your finances? Yes or No
7. Do you need help with other activities of daily living? Yes or No

ACTIVITIES OF DAILY LIVING/INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1. Do you require help with personal hygiene? Yes or No
2. Do you require help with dressing and undressing? Yes or No
3. Do you require help with eating? Yes or No
4. Do you require help with functional transfers? Yes or No
5. Do you require help with bowel and bladder management? Yes or No
6. Do you require help with walking? Yes or No
7. Do you need help completing housework? Yes or No
8. Do you need help using the telephone or other forms of communication? Yes or No
9. Do you need help using technology such as a computer? Yes or No
10. Do you need help with transportation within the community? Yes or No

HOME SAFETY SCREEN

1. Does your home have throw rugs, poor lighting, or a slippery bathtub/shower? Yes or No
2. Does your home have grab bars in bathrooms, handrails on stairs and steps? Yes or No
3. Does your home have functioning smoke alarms and CO detector? Yes or No
4. Do you feel safe in your home? Yes or No

RISK FOR FALLS SCREEN

1. Have you fallen in the past 6 months? Yes or No
2. If yes, were you injured? Yes or No