GulfView Medical Institute PL
A new approach to health.

Wellness Checklist

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

Your name: _____

Today's date: _____

Your date of birth: _____

1. What is your age?
☐ 18-64 ☐ 65-69 ☐ 70-79 ☐ 80 or older

2. Are you a male or a female?
☐ Male ☐ Female

3. During the **past four 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
☐ Extemely

4. During the **past four 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
☐ Extemely

5. During the **past four weeks**, how much bodily pain have you generally had?
☐ No pain
☐ Very mild pain
☐ Mild pain
☐ Moderate pain
☐ Severe pain

6. During the **past four weeks**, was someone available to help 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

7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?
☐ Very heavy
☐ Heavy
☐ Moderate
☐ Light
☐ Very light

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)
☐ Yes ☐ No

9. Can you go shopping for groceries or clothes without someones's help?
☐ Yes ☐ No

10. Can you prepare your own meals?
☐ Yes ☐ No

11. Can you do housework without help?
☐ Yes ☐ No

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
☐ Yes ☐ No

13. Can you handle your own money without help?
☐ Yes ☐ No

14. During the **past four weeks**, how would you rate your health in general?
☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

Continued ➡

15. How have things been going for you during the **past four weeks**?

- ☐ Very well; could hardly be better
- ☐ Pretty well
- ☐ Good and bad parts about equal
- ☐ Pretty bad
- ☐ Very bad; could hardly be worse

16. Are you having difficulties driving your car?

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

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

- ☐ Yes, usually
- ☐ Yes, sometimes
- ☐ No

18. How often during the **past four weeks** have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up	☐	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐	☐
Trouble eating well	☐	☐	☐	☐	☐
Teeth or denture problems	☐	☐	☐	☐	☐
Problems using the telephone	☐	☐	☐	☐	☐
Tiredness or fatigue	☐	☐	☐	☐	☐

19. Have you fallen two or more times in the **past year**?

☐ Yes ☐ No

20. Are you afraid of falling?

☐ Yes ☐ No

21. Are you a smoker?

- ☐ No
- ☐ Former smoker, When did you quit? _____
- ☐ Yes, and I might quit
- ☐ Yes, but I'm not ready to treat

How long did (or have) you smoke(d)? _____

Packs per day? _____

22. During the **past four weeks**, how many drinks of wine, Beer, or other alcoholic beverages did you have?

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

23. Do you exercise for about 20 minutes three or more days a week?

- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ No, I usually don't exercise that much

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

☐ Yes ☐ No

Keeping track of your medications?

☐ Yes ☐ No

25. 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

26. 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

27. What is your race? (Check all that apply)

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaskan Native
- ☐ Hispanic or Latino origin or descent
- ☐ Other

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checklist to your doctor or nurse.

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PHQ9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several Days 1	More than half the days 2	Nearly every day 3
1.) Little interest or pleasure in doing things	☐	☐	☐	☐
2.) Feeling down, depressed or hopeless	☐	☐	☐	☐
3.) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4.) Feeling tired or having little energy	☐	☐	☐	☐
5.) Poor appetite or overeating	☐	☐	☐	☐
6.) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7.) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9.) Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Total Score:		☐		

Interpretation

1-4 Minimal Depression
5-9 Mild Depression
10-14 Moderate Depression
15-19 Moderately Severe Depression
20-27 Severe Depression

Please fill in the estimated month and year you last had the following, and what was the result? (if applicable)

Colonoscopy:_____ Mammogram: _____

Pap smear: _____ Eye Exam: _____

Flu shot: _____ Pneumonia shot: _____

PSA:_____ Bone Density Scan:_____