Grace Health

Medicare Wellness Visit Assessment

Patient Information Date _____

Patient Name: _____ Birth Date _____

Address _____ Age _____
Street City, State

Assessment Questions

1. Does anyone in your immediate family or family history have/had any of the conditions listed below? *If so, please check the box next to it.*

   ❑ Diabetes ❑ Stroke ❑ High blood pressure
   ❑ High cholesterol ❑ Heart disease ❑ Cancer ❑ Mental illness

2. Do you smoke or chew tobacco? ..... ❑ No ❑ Yes – *How much?* _____
   For how long? _____

3. Do you use e-cigarettes (vaping)? ..... ❑ No ❑ Yes – *How much?* _____
   For how long? _____

4. Have you had passive smoke exposure? ..... ❑ No ❑ Yes – *What type?* _____

5. Do you drink alcohol? ..... ❑ No ❑ Yes – *How much?* _____
   For how long? _____

6. Do you eat or drink caffeine? ..... ❑ No ❑ Yes – *How much?* _____
   What type? Check all that apply: ❑ Coffee ❑ Tea ❑ Soda pop ❑ Energy drinks ❑ Other

7. Do you exercise? ..... ❑ No ❑ Yes – *How often?* _____
   How long? _____

8. Are you following a special diet? ..... ❑ No ❑ Yes – *What type?* _____

9. Have you fallen in the last year? ..... ❑ No ❑ Yes – *How many times?* _____

10. Do you use a seatbelt in the car? ..... ❑ No ❑ Yes

Confidential History – Please indicate which of the following substances you use or have used:

Substance	Previous History
❑ Marijuana	
❑ Cocaine	
❑ Methamphetamine	
❑ Heroin	
❑ IV drugs	
❑ Other _____	

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Functional Assessment

How often during the *past 4 weeks* have you been bothered by any of the following?	*Never*	*Sometimes*	*Always*
Falling or dizziness	❑	❑	❑
Trouble getting food or housing	❑	❑	❑
Trouble organizing and tasking your medicine	❑	❑	❑
Trouble bathing or getting dressed	❑	❑	❑
Trouble getting clothing or shopping	❑	❑	❑
Doing housework	❑	❑	❑
Problems with transportation	❑	❑	❑
Problems hearing well enough	❑	❑	❑
Problems getting around/walking	❑	❑	❑
Problems with your memory	❑	❑	❑
Problems with bowels or bladder	❑	❑	❑

Do you need help with any other problem not listed above? ..... ❑ No ❑ Yes – *Please list:*

Do you have an **Advance Directive**?

❑ Yes
❑ No .....*Are you interested in having an Advance Directive?* ..... ❑ No ❑ Yes
❑ Unsure.....*Do you need more information about Advance Directive?* ..... ❑ No ❑ Yes

Your Healthy Behavior

Small everyday changes can have a BIG IMPACT on your health. During the next year, which of the following changes would you be interested in? (Choose as many as you want!)

❒ Exercise more and eat better and/or lose weight
❒ Cut back or quit using/smoking tobacco
❒ Cut back or quit drinking alcohol
❒ Get help for drug or substance abuse
❒ Get a flu shot
❒ Follow up with my doctor for testing and/or treatment of high blood pressure, diabetes, & high cholesterol
❒ Commit to keep up all the healthy things I do now

❒ Other _____

Now that you have selected your healthy behavior (s) above, please choose your response to each of the questions below.

Do you want to make some small lifestyle changes in the areas you marked above?

❑ I don't want to make changes now.
❑ I want to learn more about changes I can make.
❑ Yes, and I know the changes I want to start making.

How much support do you think you would get from family or friends?

❑ I would get no support. ❑ I would get some support. ❑ I would be fully supported.

How much support would you like from *Grace Health* to make these changes?

❑ I don't want any support. ❑ I would like some support. ❑ I want to be fully supported.