

PSYCHOSOCIAL HEALTH:

Please check one response for each question:

In the past 2 weeks, how often have you been bothered by the following:

5) Feelings that caused you distress or interfered with your ability to get along socially with family or friends?	Not at all	Several days	More than half the days	Nearly every day
6) Feeling stress over health, finances, relationships or work?	Not at all	Several days	More than half the days	Nearly every day
7) Body pain?	Not at all	Several days	More than half the days	Nearly every day
8) Fatigue?	Not at all	Several days	More than half the days	Nearly every day

HEALTH AND HABITS:

Unless otherwise noted, please check one response for each question:

9) In the past 7 days, how many days did you exercise?

- 0 1 2 3 4 5 6 7

10) On days when you exercised, for how long did you exercise (in minutes)?

- _____ minutes (please provide estimate of minutes, 0-120+)
 Does not apply

11) How intense was your typical exercise?

- Light (like stretching or slow walking)
 Moderate (like a brisk walk)
 Heavy (like jogging or swimming)
 Very heavy (like fast running or stair climbing)
 I am currently not exercising

12) In the past 7 days, how often did you eat 3 or more servings of fruits and vegetables in a day?

- Not at all Several days More than half the days Nearly every day

13) In the past 7 days, how often did you eat 3 or more servings of high fiber or whole grain foods in a day?

- Not at all Several days More than half the days Nearly every day

14) How would you describe the condition of your mouth and teeth, including false teeth or dentures?

- Excellent Very Good Good Fair Poor

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MEDICARE WELLNESS VISIT ASSESSMENT

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- 15) Do you find yourself having trouble hearing people speak? Yes No
- 16) Do you wear a hearing aid/device? Yes No
- 17) Do you always use your seat belt in the car? Yes No
- 18) Do you have a fire extinguisher in your home? Yes No
- 19) Do you have a smoke detector? Yes No

FUNCTION AND MOBILITY

Unless otherwise noted, please check one response for each question:

In your present state of health, how much difficulty do you have with the following activities?

20) Preparing food and eating	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
21) Bathing yourself	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
22) Getting dressed	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
23) Using the toilet	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
24) Moving around from place to place	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me

25) Please check any aids or devices that you usually use for any of the above activities (check all that apply):

- Cane Walker Wheelchair Crutches Special or built up chair
- Built up or special utensils Devices used for dressing (button hook, zipper pull, etc.)
- None of the above

- 26) In the past year have you fallen or had a near fall? Yes No
- 27) Are you afraid of falling? Yes No
- 28) Do you have issues with balance or feeling unsteady? Yes No
- 29) Do you feel safe in your home environment? Yes No

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30) Is there anything in your home that might make you trip or slip, and fall? Yes No

31) Do you ever leak urine or stool? Yes No

32) Do you wear a liner, pad, or special underwear because of leakage? Yes No

In your present state of health, how much difficulty do you have with the following activities?

33) Shopping	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
34) Using the telephone	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
35) Housekeeping	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
36) Laundry	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
37) Driving or using transportation	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
38) Managing your own finances	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
39) Taking your own medications	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me

SIGNS OF MEMORY ISSUES

Please check one response for each question:

40) Have you experienced any memory issues or problems with thinking? Yes No

41) Have any concerns about your memory been raised by family members, friends, caretakers, or others? Yes No



SCREENING AND PREVENTIVE SERVICES

Your provider will review with you which if these screening and prevention measures are specifically recommended for you. Our records show which of these have previously been done within UW Medicine. **Please answer this section if you have had any of the following screening or preventive measures done most recently:**

Screening / Test	Please let us know where and when this was most recently done:
Pneumococcal vaccines (e.g. Prevnar, Pneumovax)	Where completed: _____ When completed: _____
Influenza Vaccine	Where completed: _____ When completed: _____
Hepatitis B Vaccine	Where completed: _____ When completed: _____
Mammogram Screening (Women)	Where completed: _____ When completed: _____ Results normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Pap Smear (Women)	Where completed: _____ When completed: _____ Results normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Colorectal Cancer Screening	Where completed: _____ When completed: _____ Results normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Diabetes screening (e.g. glucose or blood sugar testing)	Where completed: _____ When completed: _____ Results normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Cholesterol panel	Where completed: _____ When completed: _____ Results normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Bone Density Screening	Where completed: _____ When completed: _____ Results normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Eye exam	Where completed: _____ When completed: _____ Results normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

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Abdominal Aortic Aneurysm Screening	Where completed: _____
	When completed: _____
	Results normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

ADVANCED CARE PLANNING

Please check one response for each question:

Do you currently have this in place?			
42) POLST form (Physician orders for life-sustaining treatment)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know / don't remember
43) Living will (documents that make your health care wishes know, also called Advance Directive)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know / don't remember
44) Durable Power of Attorney for Medical Affairs (someone to make medical decisions for you in the event that you are unable to)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know / don't remember

45) Do you want to discuss advance care planning at your wellness visit?
 Yes No Not sure

PROVIDER SIGNATURE	PRINT NAME	PAGER	NPI	DATE	TIME
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DEPRESSION SCREENING (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle your answer to each question)	Not at all	Several days	More than half the days	Nearly Every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself --- or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Scoring _____ + _____ + _____ + _____

= Total Score: _____

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

Not difficult
at all

Somewhat
difficult

Very
difficult

Extremely
difficult

TOBACCO SCREENING	
Are you a?	<input type="checkbox"/> Never smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Current daily smoker <input type="checkbox"/> Current some day smoker <input type="checkbox"/> Chewing tobacco user <input type="checkbox"/> E-cigarette user <input type="checkbox"/> Vapor use
If former smoker , how long has it been since you last smoked?	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> 1-5 years <input type="checkbox"/> 5-10 years <input type="checkbox"/> 10-15 years <input type="checkbox"/> >15 years
How old were you when you started smoking?	
If current daily smoker , how many cigarettes per day?	<input type="checkbox"/> 5 or less <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-30 <input type="checkbox"/> 31 or more
If current daily smoker , how soon after you wake up do you smoke?	<input type="checkbox"/> within 5 min <input type="checkbox"/> 6-30 min <input type="checkbox"/> 31-60 min <input type="checkbox"/> after 60 min
If current daily smoker , are you interested in quitting?	<input type="checkbox"/> Ready to quit <input type="checkbox"/> Thinking about quitting <input type="checkbox"/> Not ready to quit

HEARING SCREEN

Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you sometimes feel that people are mumbling or not speaking clearly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you experience difficulty following dialogue in the theater or while watching TV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you find yourself asking people to speak up or repeat themselves?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you sometimes have difficulty understanding speech on the telephone ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you experience ringing or noises in your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you hear better with one ear than the other?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FUNCTION SCREEN

Do you need helping feeding yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help getting from bed to chair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help getting to the toilet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help getting dressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help bathing or showering?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help walking across the room (includes using cane or walker)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help using the telephone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help taking your medicines?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help preparing meals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help managing money (like keeping track of expenses or paying bills)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help shopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help with transportation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help climbing a flight of stairs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HOME SAFETY SCREEN

Do you have easy access to a phone at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are emergency numbers easily accessible?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have functioning smoke/carbon monoxide alarms in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have non-slip surface and grab bars in bath/shower?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you climb stairs at home, are there secure railing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ALCOHOL SCREENING

Did you have a drink containing alcohol in the past year? Yes No

If yes, how often did you have a drink containing alcohol in the past year?

monthly or less 2 to 4 times a month 2 to 3 times per week 4 or more times a week

If yes, how many drinks did you have on a typical day when you were drinking in the past year?

1 or 2 3 or 4 5 or 6 7 to 9 10 or more

If yes, how often did you have six or more drinks on one occasion in the past year?

never less than monthly monthly weekly daily or almost daily