Virginia Mason Franciscan Health

65-year-old + Medicare Wellness Visit

Name: _____

Date of birth: _____

Preferred Name: _____ (Optional) Gender pronoun(s): _____

Concern(s) you wish to discuss today: _____

Which medication(s) do you need refilled? _____

General Health

In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you eat healthy foods most of the time? ☐ Yes ☐ No

Do you always wear your seatbelt when riding in a car? ☐ Yes ☐ No

Have you had dental care within the past 12 months? ☐ Yes ☐ No

In the past 7 days, how many days did you exercise? _____ days Exercise type: _____

On days when you exercised, for how long did you exercise? _____ minutes per day

Tobacco Use

☐ No ☐ Yes In the last 30 days, have you used tobacco?

If yes, are you interested in quitting in the next month? ☐ Yes ☐ No

_____ Number of cigarettes per day _____ Number of Years

☐ No ☐ Yes Are you a former smoker?

_____ Number of cigarettes per day _____ Number of Years _____ Quit Year/Date

How often is stress/anger a problem for you? ☐ Never/rarely ☐ Sometimes ☐ Often ☐ Always

The next questions are about how you feel about different aspects of your life. For each one, tell me how often you feel that way	Hardly Ever	Some of the Time	Often
How often do you feel that you lack companionship?	1	2	3
How often do you feel left out?	1	2	3
How often do you feel isolated from others?	1	2	3

Do you think of yourself as ☐ Heterosexual/straight ☐ Homosexual/lesbian/gay ☐ Bisexual

☐ Choose not to disclose ☐ Don't know ☐ Something else _____

Do you have any sexual concerns you would like to discuss today? _____

Falls

1. Have you fallen within the past year?	☐ No	☐ Yes
2. Do you use or have you been advised to use a cane or walker to get around safely?	☐ No	☐ Yes
3. Do you feel unsteady when you are walking?	☐ No	☐ Yes
4. Do you steady yourself by holding onto furniture when walking at home?	☐ No	☐ Yes
5. Are you worried about falling?	☐ No	☐ Yes
6. Do you need to push off with your hands when you stand up from a chair?	☐ No	☐ Yes
7. Do you have some trouble stepping up onto a curb?	☐ No	☐ Yes
8. Do you often have to rush to the toilet?	☐ No	☐ Yes
9. Have you lost some feeling in your feet?	☐ No	☐ Yes
10. Do you take medicine that sometimes makes you feel lightheaded or more tired than usual?	☐ No	☐ Yes

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11. Do you take medicine to help you sleep or improve your mood?	☐ No	☐ Yes
12. Do you often feel sad or depressed?	☐ No	☐ Yes
13. Does your home have loose rugs on the floor?	☐ No	☐ Yes
14. Does your main bathroom lack grab bars?	☐ No	☐ Yes
15. Do any of your stairs lack handrails?	☐ No	☐ Yes
16. Does your home have poor lighting from bathroom to bedroom?	☐ No	☐ Yes

Function, Safety, and Hearing: Do you need help with:

Phone?	☐ No	☐ Yes	Managing meds?	☐ No	☐ Yes
Transportation?	☐ No	☐ Yes	Managing money?	☐ No	☐ Yes
Shopping?	☐ No	☐ Yes	Dressing	☐ No	☐ Yes
Preparing meals?	☐ No	☐ Yes	Bathing?	☐ No	☐ Yes
Housework?	☐ No	☐ Yes	Transferring positions?	☐ No	☐ Yes
Laundry?	☐ No	☐ Yes	**Do you have hearing difficulties?**	☐ No	☐ Yes

Mood

PHQ-9 **Over the last 2 weeks, how often have you been bothered by any of the following problems?**	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 asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite/overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself/family down	0	1	2	3
7. Trouble concentrating, i.e., reading newspaper, watching TV	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 thoughts of hurting yourself in some way	0	1	2	3

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 ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

During the past four weeks, how much bodily pain have you generally had?	☐ None	☐ Very mild	☐ Mild	☐ Moderate	☐ Severe

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GAD-7 **Over the last 2 weeks, how often have you been bothered by the following problems?**	Not at all	Several days	More than 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 it is 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

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 ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

Advance Directives

1. If you were unable to make your own health care decisions, have you designated someone to speak for you (Durable Power of Attorney for Healthcare)? ☐ Yes ☐ No

a. If yes, who?

	Name	Relationship	Phone
Primary	_____	_____	_____
Secondary	_____	_____	_____

b. Have you told them or others? ☐ Yes ☐ No

2. Have you completed the following advance care planning legal documents?

☐ No ☐ Yes Durable Power of Attorney (DPOA for Health Care)

☐ No ☐ Yes Living Will / Health Care Directive

☐ No ☐ Yes Physician Order for Life-Sustaining Treatment (POLST)

List of current Medical Providers and Suppliers (other than your Primary Care Provider):

_____

Thank you for completing this form. Please keep it until you are in the exam room. Your provider will review and discuss what is most important to you today.

If you are enrolled in MyVM, your clinic visit note will be available there for review. If not, please let us know so we can provide you with a printed copy.

Patient Name & ID#