

Medicare Total Health Assessment Questionnaire



This **Medicare Total Health Assessment** is part of your upcoming Annual Wellness Visit. Please answer the following questions about your health and day-to-day activities. This questionnaire will help your clinical team address the areas important to your overall well-being.

This questionnaire should take about 10- 20 minutes to complete. If you need help, please contact the medical staff or ask for help during your visit.

Thank you.

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I. Your Overall Health and Well-Being

1. In general, would you say your health is:

<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
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2. In general, would you say your quality of life is:

<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
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3. In general, how would you rate your physical health:

<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
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4. In general, how would you rate your mental health, including your mood and your ability to think?

<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
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5. In the past 7 days, how much did pain interfere with your day to day activities?

<input type="checkbox"/> Not at all	<input type="checkbox"/> A little bit	<input type="checkbox"/> Somewhat	<input type="checkbox"/> Quite a bit	<input type="checkbox"/> Very much
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6. 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
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
a. Feeling anxious, nervous, or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. In the past 7 days, how often were you bothered by the following?

	Never	Rarely	Sometimes	Often	Always
a. Feeling angry	<input type="checkbox"/>				
b. Feeling lonely	<input type="checkbox"/>				

10. Do any of your health conditions interfere with your daily activities?

Yes No

11. Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person?

	I Do Not Have Difficulty	Yes, I Have Difficulty	I Am Not Able To Do This Activity Unassisted
a. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Dressing and grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Getting in and out of bed or chairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Managing medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Doing household activities, like food preparation, laundry, and housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. If for any reason you have difficulty or cannot do any of the activities listed in Question 11, do you get the help that you need?

<input type="checkbox"/> I get all the help I need	<input type="checkbox"/> I could use a little more help	<input type="checkbox"/> I need a lot more help	<input type="checkbox"/> I don't need any help
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13. Do you often have problems related to your sleep, including falling asleep or staying asleep? Do you wake up with a headache or feel very sleepy during the day?

Yes No

	YES	NO
14. A fall is when your body goes to the ground without being pushed. Did you fall in the <u>past 12 months</u>?	<input type="checkbox"/>	<input type="checkbox"/>
15. In the <u>past 12 months</u>, have you had a problem with balance or walking?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you think you have a hearing problem, or do others think you have a hearing problem?	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have tooth or mouth problems that make it hard for you to eat?	<input type="checkbox"/>	<input type="checkbox"/>
18. Many people experience problems with the leakage of urine. In the <u>past 6 months</u>, have you accidentally leaked urine?	<input type="checkbox"/>	<input type="checkbox"/>
19. In the <u>last year</u>, have you or any of your friends and family felt concerned about any changes in your memory, attention, language skills, or thinking?	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you have difficulty driving, watching TV, reading, or doing any of your daily activities because of your eyesight?	<input type="checkbox"/>	<input type="checkbox"/>

II. Your Health Behaviors and Safety

21. How many days per week do you usually do moderate to strenuous physical activity, like a brisk walk?

<input type="checkbox"/> 0 days	<input type="checkbox"/> 1 day	<input type="checkbox"/> 2 days	<input type="checkbox"/> 3 days	<input type="checkbox"/> 4 days	<input type="checkbox"/> 5 days	<input type="checkbox"/> 6 days	<input type="checkbox"/> 7 days
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If you answered "0" days, skip to Question 23. Otherwise, answer Question 22.

22. On the days that you do physical activity how many minutes do you do on average?

<input type="checkbox"/>								
10	20	30	40	50	60	90	120	150+

23. How many servings of fruits and vegetables do you eat in a typical day? (A serving is 1 piece of fruit, ½ cup of fruit or vegetables, 1 cup of raw leafy vegetables, or ¾ cup of juice.)

<input type="checkbox"/>					
0 servings	1 servings	2 servings	3 servings	4 servings	5 or more servings

24. If your doctor recommended you take a low dose aspirin to prevent heart problems and stroke, are you taking it?

<input type="checkbox"/> Yes, I take low dose aspirin every day	<input type="checkbox"/> Yes, I take low dose aspirin some days	<input type="checkbox"/> No, I do not take low dose aspirin	<input type="checkbox"/> My doctor did not recommend low dose aspirin
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	YES	NO
25. Do you eat fewer than 2 meals a day?	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you always have enough money to buy the food you need?	<input type="checkbox"/>	<input type="checkbox"/>

27. Do you use any kind of tobacco, including cigarettes, cigars, pipe, snuff, or chewing tobacco?

<input type="checkbox"/> Yes	<input type="checkbox"/> No, I quit	<input type="checkbox"/> No, I have never used tobacco
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28. How many days a week do you have a drink containing alcohol?

<input type="checkbox"/> Never	<input type="checkbox"/> 1 day	<input type="checkbox"/> 2 days	<input type="checkbox"/> 3 days	<input type="checkbox"/> 4 days	<input type="checkbox"/> 5 days	<input type="checkbox"/> 6 days	<input type="checkbox"/> 7 days
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If you answered “Never drink”, skip to Question 30. Otherwise, answer Question 29.

(Medicare Total Health Assessment cont.)

29. How many drinks containing alcohol do you have on a typical day when you are drinking?

(One drink is one beer, one glass of wine, one wine cooler, or a mixed drink with one shot of hard liquor. A mixed drink with double shots counts as two drinks.)

<input type="checkbox"/>				
Less than 1 drink	1 drink	2 drinks	3 drinks	4 or more drinks

30. Do you always use a seatbelt when you drive or ride in a car?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> No, I never drive or ride in a car
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31. Are you currently sexually active?

Yes No

If “No”, skip to [Question 33.](#) Otherwise, answer [Question 32.](#)

32. If you are sexually active, do you have questions or are you interested in screening for sexually transmitted diseases?

Yes No

33. Does the place where you live have the following safety concerns?

	YES	NO
a. No working smoke alarm in one or more bedrooms or levels	<input type="checkbox"/>	<input type="checkbox"/>
b. Poor lighting or lack of hand rail on stairs	<input type="checkbox"/>	<input type="checkbox"/>
c. Slippery flooring in the tub or shower or no grab bars	<input type="checkbox"/>	<input type="checkbox"/>

III. Living Arrangements

34. Which of the following best describes where you currently live?

- Apartment, condo, trailer, house, townhouse, etc. (a living situation where meals and household help are not routinely provided by paid staff)
- Assisted living, retirement facility, etc. (a living situation where meals and household help are routinely provided by paid staff)
- Nursing Home (a living situation where nursing care is provided 24 hours a day)
- Other _____

35. Do you have someone you could call if you needed help?

- Yes
- No

IV. Advance Care Planning

36. Do you have any advance directives for your health care (for example, medical Durable Power of Attorney, Living Will, Five Wishes, CPR or Do Not Resuscitate directive)?

- Yes
- No
- I don't know

V. Demographics

37. What was the highest grade or level of school that you have completed?

- 8th grade or less
- Some high school, but did not graduate
- High school graduate or GED
- Some college or 2 year degree
- 4 year college graduate (B.A., B.S., etc.)
- More than a 4 year college degree

38. What is your current marital status?

- Married
- In a serious or committed relationship, but not married
- Divorced
- Separated
- Widowed
- Single

39. Who completed this questionnaire?

- Person to whom the questionnaire was addressed
- Family member or relative of the person to whom the questionnaire was addressed
- Friend of person to whom the questionnaire was addressed
- Professional caregiver of person to whom the questionnaire was addressed