Upson Family Physicians

Medicare Wellness Screening

Name____

Date of Birth____________________________________

Please indicate the date that you last received the following:

Colonoscopy screening ______________________

Pap smear ______________________

CT for lung cancer screening ______________________

DEXA scan (osteoporosis screening) ______________________

Mammogram ______________________

Hypertension screening ______________________

PHQ-2 ______________________

Vaccinations

Flu vaccine ______________________

Pneumonia ______________________

Shingles ______________________

Tetanus/Diptheria ______________________

Activities of Daily Living

Please circle the appropriate answer

Feeds self	Yes	No
Transfers from bed to chair independently	Yes	No
Gets to the toilet independently	Yes	No
Urinary incontinence	Yes	No
Dresses self	Yes	No
Bathes/Showers independently	Yes	No
Able to walk across the room (Includes using cane/walker)	Yes	No

Uses telephone independently	Yes	No	
Takes medication independently	Yes	No	
Prepares meals for self	Yes	No	
Manages own money (Paying bills/keeping track of expenses)	Yes	No	
Able to do moderately strenuous housework	Yes	No	
Shops for own personal items (toiletries/medications)	Yes	No	
Shops for groceries independently	Yes	No	
Able to drive	Yes	No	
Climbs a flight of stairs	Yes	No	

Hearing Evaluation

Please circle the appropriate answer

Is it difficult to follow a conversation in a noisy room?	Yes	No	Sometimes
Sometimes feel people are mumbling or not speaking clearly?	Yes	No	Sometimes
Experience difficulty following dialogue in a theater?	Yes	No	Sometimes
Difficult to understand a speaker at a public meeting?	Yes	No	Sometimes
Do you ask people to speak up or repeat themselves?	Yes	No	Sometimes
Is it easier to understand men's voices vs. women's?	Yes	No	Sometimes
Is it difficult to understand soft or whispered speech?	Yes	No	Sometimes
Sometimes have difficulty understanding speech on the phone?	Yes	No	Sometimes
Hearing problem causes embarrassment when Meeting new people?	Yes	No	Sometimes
Feel handicapped by a hearing problem?	Yes	No	Sometimes
Hearing problem causes patient to visit friends less often?	Yes	No	Sometimes

Experience ringing or noises in the ears?	Yes	No	Sometimes
Hears better with one ear than the other?	Yes	No	Sometimes
Significant noise exposure- work/recreation/military?	Yes	No	Sometimes
Patient or relatives by birth had hearing loss?	Yes	No	Sometimes

Depression Screening

Please circle the appropriate answer

Little interest or pleasure in doing things

Yes   No   More than half the days   Nearly everyday

Feeling down, depressed, or hopeless

Yes   No   More than half the days   Nearly everyday

Fall Risk Screening

Please circle the appropriate answer

Do you have a fear of falling?	Yes	No
Are there any rugs in the house to trip on?	Yes	No
Do all stairs in the home have rails?	Yes	No
Is the bathroom equipped with grab bars?	Yes	No
Does you feel off balance?	Yes	No
Have you fallen in the past year?	Yes	No

If yes, how many times? ___________

If yes, what are the circumstances around the fall?

Tripped over something   Lightheadedness/palpitations prior to the fall

Loss of consciousness   Injured

Alcohol/Tobacco Screening

Please circle the appropriate answer

Alcohol use?	Yes	No
Smoker?	Yes	No

Advance Directives

Do you have an advanced directive?	Yes	No