Stanford HEALTH CARE
STANFORD MEDICINE

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To our patients:

This Medicare health assessment questionnaire 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 5 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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Please answer the following questions to the best of your ability.

1. In general, how would you rate your overall health:

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

2. In general, how would you rate your quality of life:

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

3. In general, how would you rate your mental health, including your mood and your ability to think?

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

4. In the **past 7 days**, how much did pain interfere with your day to day activities?

☐ Not at all	☐ A little bit	☐ Somewhat	☐ Quite a bit	☐ Very Much

5. 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
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐

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6. 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
Bathing	☐	☐	☐
Dressing and grooming	☐	☐	☐
Eating	☐	☐	☐
Using the toilet	☐	☐	☐
Getting in and out of bed or chairs	☐	☐	☐
Managing medications	☐	☐	☐
Managing money	☐	☐	☐
Household activities, like food prep, laundry, and housekeeping	☐	☐	☐

7. In the **past 6 months**, have you accidentally leaked urine?

☐ No	☐ Yes

8. A fall is when your body goes to the ground without being pushed. Did you fall in the **past 12 months**?

☐ No	☐ Yes

9. Walking Status:

☐ Walk unassisted	☐ Use a cane/walker	☐ Use a wheelchair

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10. Do you think you have a hearing problem, or do others think you have a hearing problem?

☐ No	☐ Yes

11. Do you have difficulty driving, watching TV, reading, or doing any of your daily activities because of your eyesight?

☐ No	☐ Yes

12. How many servings of fruits and vegetables do you eat in a typical day?

☐ More than 5 servings	☐ 3-5 servings	☐ 1-2 servings	☐ I do not eat fruits and vegetables

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

	Yes	No
Loose rugs	☐	☐
Carbon Monoxide detector	☐	☐
Working smoke alarm	☐	☐
Good lighting in walkways	☐	☐
Solid hand rails on stairs	☐	☐
Non-slip flooring in tub or shower, or grab bars	☐	☐

14. What is your usual form of transportation?

☐ Drive self	☐ Driven by others	☐ Bus/taxi/para-transit

15. Do you have an Advance Healthcare Directive?

☐ Yes	☐ No

16. Is your Advance Healthcare Directive on file with us?

☐ Yes	☐ No

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17. To ensure optimal care coordination, please list below all providers you see on a regular basis.

_____

_____

_____

_____

_____

Please wait for your provider to complete this portion