

- Have you been to the emergency room in the past six months? Yes No
- Do you live alone? Yes No
- Do you feel safe in your current living situation? Yes No
- Is there a friend or family member who will take care of you for a few days, if needed? Yes No
- Do you live in assisted living or a nursing home? Yes No
- Are you physically active three times a week for 30 minutes? Yes No
- Have you had a fall within the last three months? Yes No
- Are you receiving home health or home medical equipment? Yes No

(If yes, please check all that apply.)

- | | | |
|--|--|--|
| <input type="checkbox"/> Oxygen | <input type="checkbox"/> Nebulizer | <input type="checkbox"/> CPAP/Bi-Pap Machine |
| <input type="checkbox"/> Tracheotomy Care | <input type="checkbox"/> Catheter Care | <input type="checkbox"/> Ostomy/Wound Care |
| <input type="checkbox"/> Tube Feedings | <input type="checkbox"/> Insulin Pump | <input type="checkbox"/> Home Infusion |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Walker/Cane | <input type="checkbox"/> Hospital Bed |
| <input type="checkbox"/> Home Speech Therapy | <input type="checkbox"/> Home Occupational Therapy | <input type="checkbox"/> Home Physical Therapy |
| <input type="checkbox"/> Home Nursing | <input type="checkbox"/> Other _____ | |

Please list all current home health or medical equipment provider(s):

Company Name	Phone	Fax

Tell us about your usual ability with everyday activities. Please choose only one box for each.

	No Help Needed	Some Help Needed	Someone does it for me
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Do you use an assistive device? Yes No *(If yes, which devices do you use and how often?)*

	Some of the time	Half of the time	Most of the time	All of the time
<input type="checkbox"/> Cane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Slide board	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Due to transportation issues, do you have difficulty getting groceries, prescriptions or doctor appointments? Yes No

Due to financial issues, do you have difficulty getting groceries, prescriptions or doctor appointments? Yes No

Height: _____ Weight: _____ Has your weight changed more than 10 pounds in the past three months? Yes No

Have you had changes in your appetite in the past three months? Yes No

On average, do you eat at least three times each day? Yes No

Are you on a special, medically necessary diet? Yes No

Do you have any food allergies? Yes No

How many different medications a day do you take, including non-prescriptions? _____ (Please list all medications below.)

Medicine Name / Dosage	Medicine Name / Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medicine? Yes No If yes, please list:

Have you ever forgotten to take your medications? Yes No
If yes, on average, how many days each week does this happen? 0 1-2 3-5 6-7

On average, how well do you sleep each night? Good Fair Poor

Do you often feel sad or blue? Yes No

Do you drink alcohol? Yes No

Do you have a history of drug or alcohol abuse? Yes No

Do you use cigarettes / tobacco products? Yes No
If yes, would you like to quit? Yes No

Have you been told by a health care professional that you have any of the following? (*Check all that apply.*)

- | | | |
|--|--|---|
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver Problems/Hepatitis |
| <input type="checkbox"/> COPD/Asthma | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Vision Issues | <input type="checkbox"/> Alzheimer's disease |
| <input type="checkbox"/> Transplant (past or future) | <input type="checkbox"/> Breathing Issues | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> High Cholesterol | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Attack | |

Complete the following by entering the dates of service for each preventive screening listed below.

Medicare Covered Test/Screening/Service	Date You Got This Test/Screening/Service	Next Test/Screening Service Due
Abdominal Aortic Aneurysm Screening		
Bone Mass Measurement		
Cardiovascular Screening		
Colorectal Cancer Screenings:		
1. Fecal Occult Blood Test		
2. Flexible Sigmoidoscopy		
3. Colonoscopy		
4. Barium Enema		
Diabetes Screening		
Diabetes Self-management Training		
Flu Shot		
Glaucoma Test		
Hepatitis B Shot		
HIV Screening		
Mammogram (<i>breast cancer screening</i>)		
Medical Nutrition Therapy Services		
Pap Test and Pelvic Exam (<i>includes breast exam</i>)		
"Welcome to Medicare" (<i>physical exam</i>)		
Annual Wellness Visit		
Pneumococcal Shot		
Prostate Cancer Screening		
Smoking Cessation Counseling		

Please Keep For Your Records

Please keep this Medicare Preventive Services Checklist for your records. Take this chart with you on every doctor's office visit. It will help you and your doctor stay on track on what screenings are right for you.

To learn more about preventive screenings, or if you need help with appointment scheduling, please contact us at 1-888-824-9802, or TTY: 711, 8 a.m. – 5 p.m. Central Time, Monday – Friday.

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Diabetes Self-management Training		
Flu Shot		
Glaucoma Test		
Hepatitis B Shot		
HIV Screening		
Mammogram (<i>breast cancer screening</i>)		
Medical Nutrition Therapy Services		
Pap Test and Pelvic Exam (<i>includes breast exam</i>)		
"Welcome to Medicare" (<i>physical exam</i>)		
Annual Wellness Visit		
Pneumococcal Shot		
Prostate Cancer Screening		
Smoking Cessation Counseling		