Parker Family Care™

Medicare Questionnaire

Screenings Required as part of Medicare Physicals

The following pages are a required component of performing and billing the Welcome to Medicare Physical and/or the Medicare Annual Wellness Visit.

The initial visit does not include many physical examination components; those will usually be addressed at later office visits.

To the best of your knowledge, when did your Medicare coverage begin:

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Printed name____

Date of Birth______________________________

Screening for Depression

Patient Name: ______________________ **DOB:** ___________ **Date:** ____________

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	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

If you checked off any problems, 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 at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

☐ Provider assessment: No further evaluation needed.

☐ Referral: ____

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Provider's Signature

Functional Activities Questionnaire

Patient Name: ______________________ **DOB:** ___________ **Date:** ____________

Please circle Yes or No			
1.	Can you get out of bed by yourself?	Yes	No
2.	Do you dress yourself without help?	Yes	No
3.	Can you prepare your own meals?	Yes	No
4.	Do you do your own shopping?	Yes	No
5.	Do you write checks and pay your own bills?	Yes	No
6.	Do you drive or have other means of transportation for traveling outside your neighborhood?	Yes	No
7.	Are you able to keep track of appointments and family occasions?	Yes	No
8.	Are you able to take medicine according to directions, dosing, etc.?	Yes	No
9.	Are you able to keep track of current events?	Yes	No
10.	Are you still able to play games of skill that you enjoy or work on a favorite hobby?	Yes	No

☐ Provider assessment: No further evaluation needed.

☐ Referral: ____

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Provider's Signature

Home Safety Questionnaire

Patient Name: ______________________ **DOB:** ___________ **Date:** ____________

	Please circle Yes or No		
1.	Do you have throwrugs on hardwood floors in your house?	Yes	No
2.	Do you have pets that stay indoors?	Yes	No
3.	Does your house have smoke alarms and carbon monoxide detectors in good working order?	Yes	No
4.	Does your bathtub contain a safety measure such as a rubber mat or strips?	Yes	No
5.	Is the area in front of your bathtub either carpeted or protected by a bath mat with rubber backing?	Yes	No
6.	Do you have night lights in your house?	Yes	No
7.	Do you have loose or frayed cords or overloaded electrical sockets in your house?	Yes	No
8.	Do you unplug household appliances when not in use?	Yes	No
9.	Do you keep medicines in a safe place and have their directions clearly labeled?	Yes	No
10.	Do you keep knives and other sharp objects put away in a safe place?	Yes	No
11.	Do you keep poisons, chemicals or other toxic substances put away in a safe place?	Yes	No
12.	Do you have furniture, such as a coffee table with sharp corners, or a rickety chair, that could cause injury?	Yes	No

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☐ Provider assessment: No further evaluation needed.

☐ Advice: ____

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Provider's Signature

Screening for Hearing Loss

Patient Name: ______________________ **DOB:** ___________ **Date:** ____________

	Please circle Yes or No		
1.	Do you have a problem hearing over the telephone?	Yes	No
2.	Do you have trouble following the conversation when two or more people talk at the same time?	Yes	No
3.	Do people complain that you turn the TV or radio volume up too high?	Yes	No
4.	Do you have to strain to understand conversation?	Yes	No
5.	Do you have trouble hearing in a noisy background?	Yes	No
6.	Do you find yourself asking people to repeat themselves?	Yes	No
7.	Do many people you talk to seem to mumble, or not speak clearly?	Yes	No
8.	Do you misunderstand what others are saying and respond inappropriately?	Yes	No
9.	Do you have trouble understanding the speech of women and children?	Yes	No
10.	Do people get annoyed because you misunderstand what they say?	Yes	No

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☐ Provider assessment: No further evaluation needed.

☐ Referral: ____

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Provider's Signature

Screening for Risk of Falls

Patient Name: ______________________ **DOB:** ___________ **Date:** ____________

	Please circle Yes or No		
1.	Do you notice numbness in your feet?	Yes	No
2.	Do your steeps feel “heavy” when you walk?	Yes	No
3.	Do you ever feel light-headed upon rising from a seated position?	Yes	No
4.	When walking, can you start and stop without difficulty?	Yes	No
5.	Do you have trouble getting out of a chair?	Yes	No
6.	Do you have any kind of difficulty when walking?	Yes	No
7.	Do you ever lose your balance with movements such as bending over, turning around, etc.?	Yes	No
8.	Have you ever fallen in the past?	Yes	No

Provider assessment: If the above answers represent risk of falling, perform the Get Up and Go test

☐ No further evaluation needed.

☐ Get Up and Go Test performed

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Provider’s Signature