Medicare Questionnaire

Home/Social Questions

1. **In the past two weeks have you experienced:**

		Not at all	Several days	More than half the days	Nearly every day
a.	**Little interest of pleasure in doing things**	O	O	O	O
b.	**Feeling down, depressed, or hopeless**	O	O	O	O
c.	**Trouble falling or staying asleep, or sleeping too much**	O	O	O	O
d.	**Feeling tired or having little energy**	O	O	O	O
e.	**Poor appetite or overeating**	O	O	O	O
f.	**Feeling bad about yourself or that you are failure or have let yourself or your family down**	O	O	O	O
g.	**Trouble concentrating on things, such as reading the newspaper or watching television**	O	O	O	O
h.	**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**	O	O	O	O
i.	**Thoughts that you would be better off dead or hurting yourself in some way**	O	O	O	O

2. **Because of health or physical problem, do you have any difficulty doing the following activities <u>without special equipment of help from another person?</u>**

		I Do Not Have Difficulty	Yes, I Have Difficulty	I Am Not Able To Do This Activity Unassisted
j.	**Bathing**	O	O	O
k.	**Dressing and grooming**	O	O	O
l.	**Eating**	O	O	O
m.	**Using the toilet**	O	O	O
n.	**Getting in and out of bed or chairs**	O	O	O
o.	**Managing medications**	O	O	O
p.	**Managing money**	O	O	O
q.	**Doing household activities, like food preparation, laundry, and housekeeping**	O	O	O

3. **If <u>for any reason</u> you have difficulty or cannot do any of the activities listed in Question 2, do you get the help that you need?**

O I get all the help I need O I could use a little more help O I need a lot more help O I don't need any help

Medicare Questionnaire

Diet/Exercise (fill in all that apply)

Special Diet followed: O None O Low fat O Low cholesterol O Renal

O Low carbohydrate O Low Sodium O Vegetarian O Calorie Controlled

	YES	NO
Do you eat fewer than 2 meals a day?	O	O
Do you always have enough money to buy the food you need?	O	O

1. **How many days per week do you usually do <u>moderate to strenuous</u> physical activity, like a brisk walk?**

O	O	O	O	O	O	O	O
0 days	1 day	2 days	3 days	4 days	5 days	6 days	7 days

Sexual Activity (Please fill in the appropriate circle)

	Yes	No
Are you currently sexually active?	O	O
Do you have questions or are you interested in screening for sexually transmitted diseases?	O	O

Hearing Assessment (Please fill in the appropriate circle)

	YES	SOMETIMES	NO
Does a hearing problem cause you to feel embarrassed when you meet new people?	O	O	O
Does a hearing problem cause you to feel frustrated when talking to members of your family?	O	O	O
Do you have difficulty hearing when someone speaks in a whisper?	O	O	O
Do you feel handicapped by a hearing problem?	O	O	O
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	O	O	O
Does a hearing problem cause you to attend religious services less often than you would like?	O	O	O
Does a hearing problem cause you to have arguments with family members?	O	O	O
Does a hearing problem cause you difficulty when listening to TV or radio?	O	O	O
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	O	O	O
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	O	O	O

Medicare Questionnaire

Fall Risk (Please fill in the appropriate circle)	**Yes**	**No**
Do you notice numbness in your feet?	O	O
Do your steps feel "heavy" when you walk?	O	O
Do you ever feel light-headed upon rising from a seated position?	O	O
When walking, can you start and stop without difficulty?	O	O
Do you have trouble getting out of a chair?	O	O
Do you have any kind of difficulty when walking?	O	O
Do you ever lose your balance with movements such as bending over, turning around, etc.?	O	O
Have you ever fallen in the past?	O	O

Alcohol and Drug Use: consider illegal drug use as well as use of prescription drugs other than prescribed.

	Yes	**No**
Have you ever felt that you ought to cut down on your drinking or drug use?	O	O
Have people annoyed you by criticizing your drinking or drug use?	O	O
Have you ever felt bad or guilty about your drinking or drug use?	O	O
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	O	O

Living Arrangements

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

   O Apartment, condo, trailer, house, townhouse, etc. (a living situation where meals and household help <u>are not</u> routinely provided)

   O Assisted living, retirement facility, etc. (a living situation where meals and household help are routinely provided by paid staff)

   O Nursing Home (a living situation where nursing care is provided 24 hours a day)

   O Other _____

2. **Do you have someone you could call if you needed help?**

   O Yes O No

Medicare Questionnaire

Home Safety Questions

	Yes	No
Are medications stored in containers and clearly marked?	O	O
Are family members aware of the dangers of smoking, especially in bed?	O	O
Do you have access to a phone should you fall?	O	O
Are working smoke alarm(s) and fire extinguisher(s) available for use?	O	O
Have throw rugs been removed or fastened down?	O	O
Are all electrical cords in working order, easily seen, and not run under rugs/carpets?	O	O
Are non-slip mats in all bathtubs and showers?	O	O
Do all stairways have a railing or banister?	O	O
Are doorways, halls, and stairs free of clutter?	O	O

Advanced Care Planning

1. **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)?**

   O Yes O No O I don't know

2. **Relationship of person completing this questionnaire to the patient?**

   O Self
   O Family member or relative
   O Friend
   O Professional caregiver