Coal Creek Family Medicine

65 and Older Wellness Checkup Form

Patient name: _____DOB: _____Todays Date: _____
Please complete this checklist before seeing your doctor or nurse.
Your responses will help you receive the best help and health care possible.

What is your age? _____ Circle one: (Male) or (Female)

Please circle the following questions

Over the last 2 weeks, how often have you been bothered by either of the following problems:
Little interest or pleasure in doing things? (YES)(NO)
If **YES** how often: __ several days __ more than ½ the days ____ everyday
Feeling down, depressed, or hopeless? (YES)(NO)
If **YES** how often: ____ several days ____ more than ½ the days ____ everyday

During the past 4 weeks:
Was someone available to help you if you needed or wanted help? (YES) (NO)
Can you get places out of walking distance without help? (YES) (NO)
Can you prepare your own meals? (YES) (NO)
Can you do your own housework without help? (YES) (NO)

Because of health problems, do you need the help of another person with your personal care needs such as eating, dressing, or getting around the house? (YES) (NO)

Have you fallen in the past year? (YES) (NO) If so, how many times? _____

Are you afraid of falling? (YES) (NO)

Have you ever used tobacco? __ Never __ Past __Current If current, do you desire to quit? (YES) (NO)

Do you exercise? (YES) (NO) If yes, how many minutes a day/week? _____Day _____Week

Do you feel you eat balanced meals? (YES) (NO)

Can you handle your own money? (YES) (NO)

Do you or others have concerns about your memory? (YES) (NO)

Do you have sleep concerns? (YES) (NO)

Have you had any changes in medications since your last appointment? (YES) (NO)

Have you had any appointments with any other provider since your last visit here? (YES) (NO)

Do you have an Advanced Directive? (YES) (NO)
OVERALL HEALTH SELF-ASSESMENT (circle one):
(POOR) (BELOW AVERAGE) (AVERAGE) (ABOVE AVERAGE) (GOOD) (EXCELLENT)

Thank you so much for completing your Wellness Check-up form. Please give this completed form to your nurse or doctor.
Provider Name: _____ Medical Assistant: _____ Date reviewed: _____