KAISER PERMANENTE®

Medicare Total Health Assessment Questionnaire

This **Medicare Total Health Assessment** 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 10- 20 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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I. Your Overall Health and Well-Being

1. **In general, would you say your health is:**

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

2. **In general, would you say your quality of life is:**

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

3. **In general, how would you rate your physical health:**

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

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

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

5. **In the <u>past 7 days</u>, how much did pain interfere with your day to day activities?**

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

6. **Over the <u>last 2 weeks</u>, 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
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐

(Medicare Total Health Assessment cont.)

7. Over the last 2 weeks, how often have you been bothered by the following problems?

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
a. Feeling anxious, nervous, or on edge	☐	☐	☐	☐
b. Not being able to stop or control worrying	☐	☐	☐	☐

8. In the past 7 days, how often were you bothered by the following?

	Never	Rarely	Sometimes	Often	Always
a. Feeling angry	☐	☐	☐	☐	☐
b. Feeling lonely	☐	☐	☐	☐	☐

10. Do any of your health conditions interfere with your daily activities?

☐ Yes ☐ No

11. 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
a. Bathing	☐	☐	☐
b. Dressing and grooming	☐	☐	☐
c. Eating	☐	☐	☐
d. Using the toilet	☐	☐	☐
e. Getting in and out of bed or chairs	☐	☐	☐
f. Managing medications	☐	☐	☐
g. Managing money	☐	☐	☐
h. Doing household activities, like food preparation, laundry, and housekeeping	☐	☐	☐

12. If <u>for any reason</u> you have difficulty or cannot do any of the activities listed in Question 11, do you get the help that you need?

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

13. Do you often have problems related to your sleep, including falling asleep or staying asleep? Do you wake up with a headache or feel very sleepy during the day?

☐ Yes ☐ No

	YES	NO
14. A fall is when your body goes to the ground without being pushed. Did you fall in the <u>past 12 months?</u>	☐	☐
15. In the <u>past 12 months</u>, have you had a problem with balance or walking?	☐	☐
16. Do you think you have a hearing problem, or do others think you have a hearing problem?	☐	☐
17. Do you have tooth or mouth problems that make it hard for you to eat?	☐	☐
18. Many people experience problems with the leakage of urine. In the past <u>6 months</u>, have you accidentally leaked urine?	☐	☐
19. In the <u>last year</u>, have you or any of your friends and family felt concerned about any changes in your memory, attention, language skills, or thinking?	☐	☐
20. Do you have difficulty driving, watching TV, reading, or doing any of your daily activities because of your eyesight?	☐	☐

II. Your Health Behaviors and Safety

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

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

If you answered "0" days, skip to <u>Question 23</u>. Otherwise, answer <u>Question 22</u>.

22. On the days that you do physical activity how many minutes do you do <u>on average</u>?

☐ 10	☐ 20	☐ 30	☐ 40	☐ 50	☐ 60	☐ 90	☐ 120	☐ 150+

23. How many servings of fruits and vegetables do you eat in a <u>typical</u> day? (A serving is 1 piece of fruit, ½ cup of fruit or vegetables, 1 cup of raw leafy vegetables, or ¾ cup of juice.)

☐ 0 servings	☐ 1 servings	☐ 2 servings	☐ 3 servings	☐ 4 servings	☐ 5 or more servings

24. If your doctor recommended you take a low dose aspirin to prevent heart problems and stroke, are you taking it?

☐ Yes, I take low dose aspirin every day	☐ Yes, I take low dose aspirin some days	☐ No, I do not take low dose aspirin	☐ My doctor did not recommend low dose aspirin

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

27. Do you use any kind of tobacco, including cigarettes, cigars, pipe, snuff, or chewing tobacco?

☐ Yes	☐ No, I quit	☐ No, I have never used tobacco

28. How many days a <u>week</u> do you have a drink containing alcohol?

☐ Never	☐ 1 day	☐ 2 days	☐ 3 days	☐ 4 days	☐ 5 days	☐ 6 days	☐ 7 days

If you answered "Never drink", skip to <u>Question 30</u>. Otherwise, answer <u>Question 29</u>.

(Medicare Total Health Assessment cont.)

29. How many drinks containing alcohol do you have on a typical day when you are drinking?
(One drink is one beer, one glass of wine, one wine cooler, or a mixed drink with one shot of hard liquor. A mixed drink with double shots counts as two drinks.)

☐ Less than 1 drink	☐ 1 drink	☐ 2 drinks	☐ 3 drinks	☐ 4 or more drinks

30. Do you <u>always</u> use a seatbelt when you drive or ride in a car?

☐ Yes	☐ No	☐ No, I never drive or ride in a car

31. Are you currently sexually active?

☐ Yes ☐ No

If "No", skip to <u>Question 33.</u> Otherwise, answer <u>Question 32.</u>

32. If you are sexually active, do you have questions or are you interested in screening for sexually transmitted diseases?

☐ Yes ☐ No

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

	YES	NO
a. No working smoke alarm in one or more bedrooms or levels	☐	☐
b. Poor lighting or lack of hand rail on stairs	☐	☐
c. Slippery flooring in the tub or shower or no grab bars	☐	☐

(Medicare Total Health Assessment cont.)

III. Living Arrangements

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

☐ Apartment, condo, trailer, house, townhouse, etc. (a living situation where meals and household help are not routinely provided by paid staff)

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

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

☐ Other _____

35. Do you have someone you could call if you needed help?

☐ Yes ☐ No

IV. Advance Care Planning

36. 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)?

☐ Yes ☐ No ☐ I don't know

V. Demographics

37. What was the highest grade or level of school that you have completed?

☐ 8th grade or less
☐ Some high school, but did not graduate
☐ High school graduate or GED
☐ Some college or 2 year degree
☐ 4 year college graduate (B.A., B.S., etc.)
☐ More than a 4 year college degree

(Medicare Total Health Assessment cont.)

38. What is your current marital status?

☐ Married
☐ In a serious or committed relationship, but not married
☐ Divorced
☐ Separated
☐ Widowed
☐ Single

39. Who completed this questionnaire?

☐ Person to whom the questionnaire was addressed
☐ Family member or relative of the person to whom the questionnaire was addressed
☐ Friend of person to whom the questionnaire was addressed
☐ Professional caregiver of person to whom the questionnaire was addressed

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