Staying Healthy for the Older Adult
Checklist

Please circle one choice for each question, leave a blank if you are not sure.

Date _____ Name _____

Choosing a Healthy Lifestyle

Diet and Exercise

1.	Do you want to lose weight, if your doctor thinks it would be good for you?	Yes	No
2.	Do you need more information about a healthy diet?	Yes	No
3.	How often do you exercise each week? (for example, once a week) _____		
	Would you like to start a regular physical exercise program to improve your health and fitness?	Yes	No

Depression

4.	During the past month have you often been bothered by:		
	Little interest or pleasure in doing things?	Yes	No
	Feeling down, depressed, or hopeless?	Yes	No

Falls and Home Safety

5.	Have you had a fall in the past year?	Yes	No
	Would you like information on making your home safer?	Yes	No

Daily Activities

6.	Do you have any problems with bathing, dressing, preparing meals, or getting to the bathroom on time?	Yes	No

Alcohol Use

7.	Do you drink alcohol-containing beverages?	Yes	No
	If so, how many alcohol-containing drinks do you drink most days? _____		
	Are you worried that you might have a problem with alcohol?	Yes	No

Smoking

8.	Are you a smoker?	Yes	No
	Would you like help to quit smoking?	Yes	No

Hearing

9.	Would you like your hearing checked?	Yes	No

Vision

10.	Have you had an eye examination in the past year?	Yes	No
	Would you like help finding an eye doctor?	Yes	No

Shots to Prevent Diseases

Hepatitis B

11A.	Are you at increased risk factors for hepatitis B (travel to far East, same sex male partner, or multiple sexual partners)?	Yes	No

Flu Shots

11B.	Are you interested in the flu shot when it is time?	Yes	No

Pneumonia Shots

11C.	Have you ever had a pneumonia shot?	Yes	No
	Are you interested in having a pneumonia shot?	Yes	No

Tetanus / Diphtheria (Td) Shots

11D.	Do you need a Td booster (none in the past 10 years)?	Yes	No

Tests to Find Diseases or Conditions Early

Blood Pressure

12.	Do you have questions about your blood pressure?	Yes	No
	Do you have a family history of blood pressure problems?	Yes	No
	Do you have a history of blood pressure problems?	Yes	No
	Are you currently on any blood pressure medication?	Yes	No

Cholesterol

13.	Have you had a cholesterol test in the past five years?	Yes	No
	Are you interested in having your cholesterol checked?	Yes	No

Electrocardiogram (ECG)

14.	Have you had an ECG in the last five years?	Yes	No
	Are you interested in having an ECG today?	Yes	No
	Note: If you are having a "Welcome to Medicare" visit, an ECG test is required and will be paid for by Medicare.		

Diabetes Screening and Fasting Plasma Glucose (FPG)

15.	Do you have any diabetes risk factors (heart disease, family history of diabetes, high blood pressure, high cholesterol, overweight, or given birth to a large baby)?	Yes	No
	Have you had an FPG test in the past year?	Yes	No
	Are you interested in having an FPG test?	Yes	No
	Note: If you are having a "Welcome to Medicare" visit, an FPG test is required and will be paid for by Medicare.		

Tests to Find Diseases or Conditions Early, continued

Osteoporosis

16.	Have you had a Bone Density Test (BMD) test in the last two years?	Yes	No
	Are you interested in having a BMD test?	Yes	No

Skin Cancer

17.	Do you have any spots or bumps that have changed in size, shape, color, or appearance that worry you?	Yes	No

Colon Cancer

18.	Are you at increased risk for colorectal cancer (personal history of colon polyps, family history of colorectal cancer, breast cancer, and cancer of the ovaries/uterus)?	Yes	No
	Have you had a screening test for colorectal cancer (colonoscopy, sigmoidoscopy, or fecal occult blood test)?	Yes	No
	If yes, what test and when? _____		
	Are you interested in a screening test for colorectal cancer?	Yes	No

Breast Cancer — Women Only

19.	Have you, your sisters, or mother ever had breast cancer?	Yes	No
	Have you had a mammogram in the past two years?	Yes	No
	Are you interested in getting a mammogram?	Yes	No

Cervical Cancer — Women Only

20.	When was your last Pap test? _____		
	Did you have Pap tests at least every other year for the ten years before the last Pap?	Yes	No
	Were the results normal?	Yes	No
	Are you interested in getting a Pap test?	Yes	No

Prostate Cancer — Men Only

21.	Do you have a father or brother with a history of prostate cancer?	Yes	No
	Have you had a prostate cancer screening (a PSA or digital rectal exam) in the past year?	Yes	No
	Are you interested in having a prostate cancer screening?	Yes	No