Community HealthChoices | pa health & wellness

PA HealthWellness.com | 1-844-626-6813 (TTY: 711)

Your Preventative Care Checklist - Before You See Your Provider

Participant Name: _____

Date of Birth: _____ Today's Date: _____

1. Have you experienced any major life events since your last visit? ☐YES or ☐NO
   (Example: Marriage, death in family, moved, new family member, graduations, etc.)

2. Do you have a good support team and social network? *(Example: Friends or family)* ☐YES or ☐NO

3. Physical Health: *(Example: Walking, sleeping, managing stress, maintaining health conditions, weight control, blood pressure)*
   - a. In general, on a scale 1 to 5, how do you rate your physical health? *(1 = Poor, 5 = Excellent):* _____

   Specific Physical Health Questions:
   - b. Bladder Control: Are you having urinary problems? ☐YES or ☐NO
   - c. Risk of Falling: Have you fallen recently OR have times where it is hard to keep your balance? ☐YES or ☐NO
   - d. Do you exercise for about 20 minutes, 3 or more days a week? ☐YES or ☐NO

4. Mental Health:
   - a. In the past 4 weeks, have you felt calm and peaceful? ☑YES or ☐NO
   - b. In the past 4 weeks, have you felt downhearted and sad? ☐YES or ☐NO

5. Reflecting on your overall health within the last year, you would say your health today is: ☐Worse or ☐The Same or ☐Better
   We encourage you to discuss ways to improve your overall health with your provider.

6. What hardships /challenges do you have in getting the care YOU need?
   (Example: Lack of transportation, financial support, access to care, troubles with focusing, having memory problems lately?)

Complete this section as best as you can. Then, share with your provider. This helps with identifying any gaps in care.

SCREENING / TEST	DATE
Annual Wellness Visit / Physical	
Flu Shot	
Recent Vaccines *(Examples: Covid, Pneumonia/Shingles/Hep B, etc.)*	
Vaccine:	
Vaccine:	
Vaccine:	
Vaccine:	
Blood Panel	
Dental Exam	
Hearing Exam	
Colon Cancer Screening (45-75 years)	
Breast Cancer Screening (50-75 years)	
DIABETIC SCREENINGS	**DATE**
Retinal Eye Exam	
Foot Exam	
A1C Test	
Kidney Screening / Test	

SPECIALIST NAME	SPECIALTY

YOUR CURRENT MEDICATION LIST *(Prescription, OTC, Supplement, Herbs+Teas)*

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-626-6813 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-844-626-6813 (TTY: 711) o hable con su proveedor.

注意：如果您说 中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-844-626-6813（文本电话：711）或咨询您的服务提供商。

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Your managed care plan may not cover all your health care expenses. Read your Participant handbook carefully to determine which health care services are covered.