PRINCETON Medical Group

Name ______________________________ **Date of Birth** ____ /____ /____ MR#______________

HEALTH RISK ASSESSMENT FOR MEDICARE WELLNESS VISIT

PATIENT DEMOGRAPHICS

Please list specialists you see: (such as cardiologist/eye doctor/physical therapist)

Name Specialty

____

____

____

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MEDICARE PREVENTIVE - HPI

Do you have Advance Directives/Living Will? ☐ Yes ☐ No
Do you feel you have a hearing problem? ☐ Yes ☐ No

Over the past 2 weeks have you felt:
0 = not at all 1= several days 2 = more than half of the days 3= nearly every day

1) Little interest or pleasure in doing things 0 1 2 3
2) Feeling down, depressed, or hopeless 0 1 2 3

Do you have concern for your memory? ☐ Yes ☐ No
Any changes to your family's medical history: ☐ Yes ☐ No

If yes please list: ____

Any recent hospital stays? ☐ Yes ☐ No

Do you use any tobacco products: ☐ Yes ☐ No
If yes, circle one: Cigarettes, chew, snuff, pipes, cigars, electronic cigarettes, other: _________
If yes, are you interested in quitting tobacco? ☐ Yes ☐ No

How many times in the past year have you had 4 or more **alcoholic drinks** in a day? (circle one)
1-2, 3-4, 5+, I don't drink

Do you need help from others to perform activities such as:

Preparing food and eating	☐ Need help	☐ Do not need help
Bathing yourself and getting dressed	☐ Need help	☐ Do not need help
Using the toilet	☐ Need help	☐ Do not need help
Getting out of bed into a chair	☐ Need help	☐ Do not need help
Paying bills	☐ Need help	☐ Do not need help
Buying groceries and housekeeping	☐ Need help	☐ Do not need help
Driving	☐ Need help	☐ Do not need help
Go up and down stairs	☐ Need help	☐ Do not need help

Do you use any assistive devices: ☐ Yes ☐ No
If yes, circle one: Cane, Walker, Crutches, Wheel chair, Shower chair, other ________________

Do you exercise regularly? ☐ Yes ☐ No
Have you fallen in the past 6 months? ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No

MEDICATION MODULE

Any new medications/supplements since your last visit: ☐ Yes ☐ No
If yes, please list your new medications:

____
____

How would you rate your health? (circle one) Poor Fair Good Excellent

Reviewed: ____ **Date** _________________________________