HEALTH RISK ASSESSMENT FOR MEDICARE WELLNESS VISIT

Name _____ **Date of Birth** _____**MR#**_____

Any changes to your family's medical history: ☐ Yes ☐ No

If yes please list: _____

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

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

Name	Specialty

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 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

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 an Advance Directives/Living Will? ☐ Yes ☐ No

Do you feel you have any vision problems? ☐ Yes ☐ No

Do you feel you have a hearing problem? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Do you have concern for your memory? ☐ Yes ☐ No

Any recent hospital stays or Emergency room Visits? ☐ Yes ☐ No

Have you fallen in the past year? ☐ Yes ☐ No

Did falls result in an Injury: _____

How many fall have you had in past year? _____

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

Provider Reviewed: _____ Date: _____