

HEALTH RISK ASSESSMENT FOR MEDICARE WELLNESS VISIT

Name _____ Date of Birth _____ MR# _____

1. Any changes to your family's medical history? Yes No

If yes, please list: _____

2. Any new medications/supplements since your last visit? Yes No

If yes, please list your new medications:

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

| Name | Specialty |
|------|-----------|
|------|-----------|

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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

| | | |
|--------------------------------------|------------------------------------|---|
| Preparing food and eating | <input type="checkbox"/> Need help | <input type="checkbox"/> Do not need help |
| Bathing yourself and getting dressed | <input type="checkbox"/> Need help | <input type="checkbox"/> Do not need help |
| Using the toilet | <input type="checkbox"/> Need help | <input type="checkbox"/> Do not need help |
| Getting out of bed into a chair | <input type="checkbox"/> Need help | <input type="checkbox"/> Do not need help |
| Paying bills | <input type="checkbox"/> Need help | <input type="checkbox"/> Do not need help |
| Buying groceries and housekeeping | <input type="checkbox"/> Need help | <input type="checkbox"/> Do not need help |
| Driving | <input type="checkbox"/> Need help | <input type="checkbox"/> Do not need help |
| Going up and down stairs | <input type="checkbox"/> Need help | <input type="checkbox"/> Do not need help |

5. Do you use any assistive devices? Yes No

If yes, circle: Cane, Walker, Crutches, Wheel chair, Shower chair, other _____

6. Do you have any bladder control issues or leaking urine? Yes No

7. Do you use any tobacco products? Yes No

If yes, circle: cigarettes, chew, snuff, pipes, cigars, electronic cigarettes, other: _____

If yes, are you interested in quitting tobacco? Yes No

8. Do you consume alcohol? Yes No

9. In the past year, have you had 4 or more alcoholic drinks in a day? Yes No

If yes, circle how many times this happened: 1-2 days, 3-4 days, or 5+ days

