HEALTH RISK ASSESSMENT FOR MEDICARE ANNUAL 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	☐ 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
Going up and down stairs	☐ Need help	☐ 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 or vape 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 happed: 1-2 days, 3-4 days, or 5+ days

10. Do you use any *illegal* drugs or take any prescription medications *that have not been prescribed to you*? ☐ Yes ☐ No

If yes, please describe ______________________________

11. What is your current level of pain? (Please circle)

(None) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

12. 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

13. Do you have an Advance Directives/Living Will? ☐ Yes ☐ No

Name of your health care proxy: ______________________________

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

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

16. Do you exercise regularly? ☐ Yes ☐ No

17. Have you had any changes with your memory in the past year? ☐ Yes ☐ No

18. Any recent hospital stays or emergency room visits? ☐ Yes ☐ No

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

How many falls in the past year? ______________________________

Did falls result in an injury? ______________________________

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

Provider Who Reviewed: ______________________________ **Date:** ____________________