HEALTH RISK ASSESSMENT FOR MEDICARE ANNUAL WELLNESS VISIT

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

Date of Annual Wellness Visit Appointment _____

1. **Any changes to your personal medical history?** ☐ Yes ☐ No

If yes, please list: _____

2. **Any changes to your family medical history?** (Related family members) ☐ Yes ☐ No

If yes, please list: _____

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

_____

_____

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

Name	Specialty

5. **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

6. **Do you use any assistive devices?** ☐ Yes ☐ No

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

7. **Do you have any bladder control issues or leaking of urine?** ☐ Yes ☐ No

8. **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

9. **Do you consume alcohol?** ☐ Yes ☐ No

10. **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

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

If yes, please describe _____

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

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

13. **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) Feeling down, depressed, or hopeless 0 1 2 3

2) Little interest or pleasure in doing things 0 1 2 3

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

Name of your health care proxy: _____

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

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

17. **Do you exercise regularly?** ☐ Yes ☐ No

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

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

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

How many falls in the past year? _____

Did falls result in an injury? _____

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

Provider Who Reviewed: _____ **Date:** _____