

Name:

Date of Birth:

Date of Service: \_\_\_\_\_

## Medicare Annual Wellness Visit – Health Risk Assessment

### General Health

1. How is your overall health
  - a. Excellent
  - b. Good
  - c. Fair
  - d. Poor
  - e. I don't know
2. How is your mouth and teeth health?
  - a. Excellent
  - b. Good
  - c. Fair
  - d. Poor
  - e. I don't know
3. In the past 6 months, how many times have you been seen in the emergency room?
  - a. 0
  - b. 1-2
  - c. 3-4
  - d. 5+
  - e. I don't know
4. In the past 6 months, how many times have you been admitted to the hospital
  - a. 0
  - b. 1-2
  - c. 3-4
  - d. 5+
  - e. I don't know
5. In the past 2 weeks, have you experienced any of the following?
  - a. Unexplained weight loss
  - b. Change in appetite
6. Do you have problems with your vision?
  - a. Yes, I use \_\_\_ contact lenses \_\_\_ glasses
  - b. Yes, and I do not use contact lenses or glasses
  - c. No
7. Do you have problems with hearing
  - a. Yes, and I use hearing devices to help me hear
  - b. Yes, and I do not use hearing devices to help me hear
  - c. No

8. Please list any specialty or other care providers that participate in your healthcare

Specialty	Provider Name
<b>Cardiologist</b>	
<b>Pulmonologist</b>	
<b>Endocrinologist</b>	
<b>Gynecologist</b>	
<b>Dermatologist</b>	
<b>Ear, Nose, Throat</b>	
<b>Eye Doctor</b>	
<b>Dentist</b>	
<b>Physical Therapist</b>	
<b>Other:</b> _____	

### Activities of Daily Living

1. In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your own medications?
  - a. Yes, please explain \_\_\_\_\_
  - b. No
2. In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking or using the toilet?
  - a. Yes, please explain \_\_\_\_\_
  - b. No

### Functional Ability

1. How long can you walk or move around before needing a break?
  - a. 0-5 minutes
  - b. 5-15 minutes
  - c. 15-30 minutes
  - d. 30 minutes to 1 hour
  - e. Longer than 1 hour
2. Do you use any of the following devices?
  - a. Cane
  - b. Walker
  - c. Crutches
  - d. Wheelchair
  - e. I do not use any of these
3. Do you have problems with balance?
  - a. Yes
  - b. No
4. Have you fallen in the last 6 months?
  - a. Yes
  - b. No

## Pain

1. In the past 2 weeks, how often have you felt pain?
  - a. Always
  - b. Usually
  - c. Sometimes
  - d. Rarely
  - e. Never
2. If you have felt any pain, rate your pain on a scale of 0-10, 0 being no pain and 10 being the worst pain. \_\_\_\_/10
3. If you have felt any pain, where is the pain? \_\_\_\_\_
4. If you have felt any pain, how do you treat the pain?
  - a. Medication
  - b. Rest
  - c. Heat or Cold
  - d. Therapy
  - e. Other \_\_\_\_\_
  - f. No treatment

## Physical Activity

1. On average, how many days a week do you exercise? \_\_\_\_ days

\*if you answered is 0, is there an illness or injury preventing you from exercising? \_\_\_\_ NO \_\_\_\_ Yes  
Illness/Injury: \_\_\_\_\_

2. On the days that you exercise, how long do you exercise?
  - a. 0-30 minutes
  - b. 30 minutes to 1 hour
  - c. More than 1 hour
  - d. I don't exercise
3. How intense is your typical exercise?
  - a. Light – stretching or slow walking
  - b. Moderate - like brisk walking
  - c. Heavy – like jogging, swimming
  - d. Very heavy – like fast running
  - e. I do not exercise
4. What types of exercise do you enjoy? \_\_\_\_\_

## Nutrition

1. How many servings of fruit and vegetables do you usually eat in a day?
  - a. None
  - b. 1-2
  - c. 3-4
  - d. 5+
  - e. I don't know

2. How many servings of fiber or whole grain foods do you usually eat in a day?
  - a. None
  - b. 1-2
  - c. 3-4
  - d. 5+
  - e. I don't know
3. How many servings of meat, fish or other protein do you usually eat in a day?
  - a. None
  - b. 1-2
  - c. 3-4
  - d. 5+
  - e. I don't know
4. How many servings of fried or high-fat food do you usually eat in a day?
  - a. None
  - b. 1-2
  - c. 3-4
  - d. 5+
  - e. I don't know

## **Home and Safety**

1. What is your living situation?
  - a. Alone
  - b. With spouse/family
  - c. With a friends or roommate
  - d. In a nursing home or assisted living facility
  - e. I don't have a place to live
  - f. Other
2. Do you feel safe at home?
  - a. Yes
  - b. No
3. Does your home have working smoke alarms?
  - a. Yes
  - b. No
4. Do you always fasten your seatbelt when riding in a vehicle?
  - a. Yes
  - b. No

## **Social/Emotional Support**

1. Which of the following applies to you? (please select all that apply)
  - a. I have a supportive family
  - b. I have supportive friends
  - c. I am involved in church, clubs or other group activities
  - d. None of these apply

2. How often do you get the social and emotional support you need?
  - a. Always
  - b. Usually
  - c. Sometimes
  - d. Rarely
  - e. I do not get the support I need
3. In the past two weeks, have you felt nervous, anxious or on edge?
  - a. Always
  - b. Usually
  - c. Sometimes
  - d. Rarely
  - e. Never
4. How often is stress a problem for you in handling things such as:
  - Your health?
  - Your finances?
  - Your family or social relationships?
  - Your work?
    - a. Always
    - b. Usually
    - c. Sometimes
    - d. Rarely
    - e. Never

## **Sleep**

1. On average how many hours of sleep do you get each night? \_\_\_\_\_ hours
2. In the past 7 days, how often have you felt sleepy during the day time?
  - a. Always
  - b. Usually
  - c. Sometimes
  - d. Rarely
  - e. Never

## **Advance Directive**

1. Do you have a health care power of attorney or a living will?
  - a. Yes
  - b. No
  - c. I would like more information

**Do you have any questions or concerns for the provider?** \_\_\_\_\_

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Preventative and Wellness Recommendations for: «FirstName» «LastName»

<u>Preventative Screening</u>	<u>Recommended Frequency</u>	<u>Date and Result of Most Recent Screening</u>
Height (in) Weight (lb.) BMI	Annually	
Blood Pressure	Annually	
Vision Check	Every 3 Years	
Abdominal Aortic Aneurysm (AAA)	Once between the age of 65-75 and for those who have smoked 100+ cigarettes in a lifetime	
Breast Cancer Screening (Mammogram)	Every two years between the age of 50-74	
Cervical Cancer Screening (PAP Smear)	Every three years ages 21-64, every five years with HPV testing ages 30-65	
Osteoporosis Screening	Every two years for women ages 60-64 with risk factors	
Cholesterol Testing	Annually beginning at age 20 with risk factors	
Diabetes Screening	With a sustained BP >/+ 135/80 mmHg	
Colorectal Cancer Screening	Annually for Fecal Occult Blood Stool (FOBS), Every five years for Sigmoidoscopy with FOB, every 10 years for a colonoscopy, every three years for a Cologuard	
Sexually Transmitted Infection (STI)	As necessary for those with risk factors	
Depression Screening	As necessary for those with risk factors	
Alcohol Misuse Screening	As necessary for those with risk factors	
Pneumococcal Vaccine	1-2 doses before age 64, 1 dose after age 65+	
Influenza Vaccine	Annually	

Personalized risk factors and health advice: \_\_\_\_\_

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