

Medicare Annual Wellness Visit

Health Risk Assessment

Name _____

Date of birth _____

Circle your responses.
Your answers will be kept confidential.

General health

How would you rate your health compared to others your age?	Worse	Same	Better
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Hearing and vision

1. Do you feel that a hearing difficulty limits your life?	Yes	No
2. Do you feel that a vision difficulty limits your life?	Yes	No

Activities of daily living

1. Do you need help with dressing, eating, bathing, going to the bathroom, walking, or getting in or out of bed?	Yes	No		
2. Do you need help with preparing meals, transportation, shopping, managing your finances, keeping house, making calls, or taking your medicine?	Yes	No		
3. If you drive, have you had a car accident in the last year, or have you been asked to stop driving?	Yes	No	I do not drive	
4. Who do you live with?	Alone	Partner /spouse	Child	Parent
	Other:			
5. Are you working or volunteering?	Yes	No		
<i>If you do, what do you do, and for how many hours a week?</i>	< 10	11-20	21+	

Home safety

Does your home have throw rugs, poor lighting, a slippery bathtub or shower or other hazards?	Yes	No
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Fall risk (STEADI questions — Stopping Elderly Accidents, Deaths and Injuries)

1. Have you fallen in the past year?	Yes	No
a. <i>If you have fallen</i> , how many times?		
b. <i>If you have fallen</i> , were you injured?	Yes	No
2. Do you feel unsteady when standing or walking?	Yes	No
3. Do you worry about falling?	Yes	No

► **If you answered yes to any of the above 3 questions**, please also answer the following:

4. Do you use (or were you told to use) a cane or walker to get around safely?	Yes	No
5. Do you have to steady yourself by holding onto furniture when moving about your home?	Yes	No
6. Do you need to push with your hands to stand up from a chair?	Yes	No
7. Do you have trouble stepping up onto a curb?	Yes	No
8. Do you often have to rush to the toilet?	Yes	No
9. Have you lost some of the feeling in your feet?	Yes	No
10. Do you take any medicine that makes you feel light-headed or tired?	Yes	No
11. Do you take medicine to help you sleep or improve your mood?	Yes	No
12. Do you feel sad or depressed?	Yes	No

Continue here.

Incontinence screening

Do you have trouble holding your bowels or bladder?	Yes	No
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Advance care planning

Do you have an Advance Directive with designation of a Health Care Representative/Power of Attorney?	No	Yes	Not sure
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Nutrition

1. How is your appetite?	Poor	Fair	Good
2. Have you lost weight without meaning to in the last year?	Yes	No	
3. Do you eat two or more servings of fruits and vegetables every day?	No	Yes	

Exercise

How many days a week do you exercise?	
<i>If you exercise:</i> What do you do? For about how many minutes each time?	

Substances

1. Do you smoke or chew tobacco? <i>If you do, how much and how often?</i>	Yes	Not currently	Never
2. Do you drink alcohol?	Yes	Not currently	Never
If you drink alcohol, how often and how much?	<i>I drink...</i> Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week <i>I drink...</i> 1-2 2-4 5-6 7-9 10+ ...drinks in a typical day when I'm drinking.		
<i>Standard drinks are 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of liquor each</i>			
3. Do you use any recreational drugs? <i>If you've used anything in the last year, please list.</i>	Yes	Not currently	Never
	Marijuana Others: _____		

Depression screening (PHQ-2/9)

Over the last 2 weeks, how often have you been bothered by any of the following?

Please circle one response for each question.

	Not at all	Several days	More than half the days	Nearly every day
1. Do you have little interest or pleasure in doing things?	0	1	2	3
2. Do you feel down, depressed or hopeless?	0	1	2	3

► **If the total score from the above questions is 3 or more**, please also answer the following:

	Not at all	Several days	More than half the days	Nearly every day
3. Do you have trouble falling asleep, staying asleep or are you sleeping too much?	0	1	2	3
4. Do you feel tired or have little energy?	0	1	2	3
5. Do you have poor appetite or overeating?	0	1	2	3
6. Do you feel bad about yourself, or feel that you're a failure or have let yourself or your family down?	0	1	2	3
7. Do you have trouble concentrating on things, such as reading or watching television?	0	1	2	3
8. Do you move or speak so slowly that other people have noticed? Or, the opposite — have you been so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
9. Have you had thoughts that you would be better off dead, or of hurting yourself?	0	1	2	3
10. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all		Very difficult	
	Somewhat difficult		Extremely difficult	

REVIEW OF SYSTEMS

*****Circle the items in each category that presently cause you problems or discomfort*****

General

Recent Weight Change
Fever/chills
Night sweats
Fatigue
Malaise/feeling ill

Allergic/Immunologic

Sneezing/runny nose
Itchy/irritated eyes
Nasal/sinus congestion
Frequent colds/illness
Recurrent pneumonia
Recurrent sinus infections

Integumentary (skin/breast)

Rash or itching
Change in skin color
Change in hair or nails
Varicose veins
Breast Pain
Breast Lump
Breast discharge
Skin ulcer
Skin change/growth/lesion
Skin infection

Eyes

Eye pain
Eye redness
Eye discharge
Vision changes
Blurred/double vision

Ears/Nose/Throat/Mouth

Hearing Loss or ringing
Earaches or drainage
Sinus problems
Nose bleeds
Sinus/face pain
Bad Breath or bad taste
Sore throat or voice change
Swollen glands in neck

Respiratory

Cough
Coughing/spitting blood
Shortness of breath
Wheezing
Snoring

Cardiovascular

Chest pain
Palpitation/irregular heartbeat
Rapid heartbeat
Shortness of breath
Swelling of feet, ankles or hands

Gastrointestinal

Loss of appetite
Nausea or vomiting
Heartburn/reflux
Abdominal pain
Diarrhea
Constipation
Change in bowel movements
Rectal bleeding/blood in stool
Rectal/anal pain
Bowel incontinence

Genitourinary

Frequent/urgent urination
Burning/painful urination
Blood in urine
Difficulty with urination
Incontinence/dribbling
Sexual difficulty
Painful periods
Heavy periods
Irregular periods
Vaginal discharge
Urethral discharge

Musculoskeletal

Joint Stiffness
Joint pain
Joint Swelling
Muscle weakness

Muscle pain/cramps
Limb pain/injury
Back pain/injury
Neck pain/injury
Cold extremities
Difficulty walking

Neurological

Headaches
Concussion
Light headed/dizzy
Fainting/collapse
Seizures
Numbness/tingling
Weakness
Tremors
Paralysis
Head Injury

Endocrine

Glandular/hormone problem
Hot flashes/night sweats
Excessive thirst/urination
Heat or cold intolerance
Dry skin
Skin/nail changes
Change in hat or glove size

Hematological/Lymphatic

Slow to heal after cuts
Easy bleeding or bruising
Vein problems
Swollen glands

Psychiatric

Sadness/Grief
Depression
Panic/Anxiety
Stress
Hallucinations
Sleep problems
Substance abuse
Alcohol abuse
Suicidal thoughts

Patient Signature: _____ **Today's Date:** _____

Print Patient Name: _____ **Date of Birth:** _____