Medicare Wellness Visit
Health Risk Assessment

Thank you for completing this form before your Medicare visit. Please bring this form with you to your appointment. If you need help filling out this form, the clinic staff will help you.

OFFICE USE ONLY

ABN form signed? ☐ Yes ☐ No

Financial waiver signed for Medicare replacement plans? ☐ Yes ☐ No

- Are you **currently** seeing any other doctors? ☐ Yes ☐ No (If yes, please list below)

Doctor's name: _____ Specialty: _____
Doctor's name: _____ Specialty: _____
Doctor's name: _____ Specialty: _____

- What company, if any, do you use to for medical supplies such as syringes, adult diapers, home safety supplies, oxygen supplies, and devices like a walker or a cane?

Company Name: _____

GENERAL

1. How have things been going for you in the past four weeks?

☐ Very well; could hardly be better
☐ Pretty well
☐ Good and bad parts about equal
☐ Pretty bad
☐ Very bad; couldn't be worse

2. How would you rate your physical health?

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

3. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ I do not have any health problems

DEPRESSION

4. Over the past two weeks, how often have you felt down depressed or hopeless?

- ☐ Not at all
- ☐ Several days
- ☐ More than half of the days
- ☐ Nearly every day

5. Over the past two weeks, how often have you felt little interest or pleasure in doing things you usually enjoy?

- ☐ Not at all
- ☐ Several days
- ☐ More than half of the days
- ☐ Nearly every day

SAFETY AND FALL RISK

6. Do you feel safe from abuse in your home?

- ☐ Yes
- ☐ No

7. Are you having difficulties driving your car?

- ☐ Yes, often
- ☐ Sometimes
- ☐ No
- ☐ I do not drive a car

8. Do you always fasten your seatbelt when you are in a car?

- ☐ Yes, usually
- ☐ Yes, sometimes
- ☐ No

9. Have you fallen one or more times in the past year?

- ☐ Yes
- ☐ No

10. Are you afraid of falling?

- ☐ Yes
- ☐ No

11. Do you use any of the following?

- ☐ Cane, wheelchair, walker
- ☐ Brace or prosthesis
- ☐ Hearing aid
- ☐ Dentures
- ☐ Glasses
- ☐ Raised toilet seat, bathtub bars or toilet bars
- ☐ Devices for dressing, eating or bathing
- ☐ Emergency Alert System
- ☐ I do not use any of these

12. Have you been given any information to help you with keeping track of your medications?

- ☐ Yes
- ☐ No

13. How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medicine
- ☐ I always take them as prescribed
- ☐ Sometimes I take them as prescribed
- ☐ I seldom take them as prescribed

HABITS AND BEHAVIORS

14. Are you a smoker?

- ☐ No
- ☐ Yes, and I might quit
- ☐ Yes, but I am not ready to quit

15. During the past four weeks, how many drinks of wine, beer or other alcoholic beverages did you have?

- ☐ 10 or more per week
- ☐ 6-9 drinks per week
- ☐ 2-5 drinks per week
- ☐ One drink or less per week
- ☐ I do not drink any alcohol at all

16. During the past four weeks, what was the hardest level of physical activity you could do for at least two minutes?

- ☐ Very hard
- ☐ Hard
- ☐ Moderate
- ☐ Light
- ☐ Very light

17. Do you have a regular exercise program?

- ☐ Yes
- ☐ No

18. Do you exercise for about 20 minutes three of more days a week?

- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ No, I usually do not exercise this much

ACTIVITIES OF DAILY LIVING AND SOCIAL SCREENINGS

19. During the past four weeks, has your physical or emotional health limited your social activities with family, friends, neighbors or groups?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

20. Do you need help with any of the following?

- ☐ Getting places out of walking distance without help
- ☐ Going shopping for groceries or clothes
- ☐ Preparing your own meals
- ☐ Housework
- ☐ Handling your own money
- ☐ Personal care needs:
  - ☐ Eating
  - ☐ Bathing
  - ☐ Dressing
  - ☐ Transferring
  - ☐ Using the toilet
  - ☐ Walking
  - ☐ Continence (controlling urination)
- ☐ I do not need help around the house

HEALTH QUESTIONS

21. In the past four weeks have you been bothered by any of the following?

- ☐ Dizzy when standing up
- ☐ Trouble eating well
- ☐ Teeth or denture problems
- ☐ Tiredness or fatigue
- ☐ Trouble seeing
- ☐ Foot problems
- ☐ Trouble thinking or remembering
- ☐ Trouble sleeping
- ☐ I am not bothered by any of these problems

22. Do you have trouble hearing the television or radio when others do not?

- ☐ Yes
- ☐ No

23. Do you have to strain or struggle to hear or understand conversations?

- ☐ Yes
- ☐ No

24. In the past six months, have you experienced urinary leakage, also sometimes called bladder control problems?

- ☐ Yes
- ☐ No

END OF LIFE

25. If you became too sick to speak for yourself, who would decide about medical treatment for you?

- ☐ Family member: _____
- ☐ Friend: _____
- ☐ My doctor: _____
- ☐ Other: _____
- ☐ I am not sure

26. Have you completed an Advance Directive?

- ☐ Yes
- ☐ No

27. Have you completed a Physician Order for Life Sustaining Treatment (POLST)?

- ☐ Yes
- ☐ No