HEALTH RISK ASSESSMENT FOR MEDICARE ANNUAL WELLNESS VISIT

Patient Name _____ Date ___ / ___ / _____

FAMILY HISTORY

use ✓ to indicate positive history

	Father	Mother	Grandmother	Grandfather	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased (list age)										
Diabetes										
Chronic Lung Disease										
Hypertension										
Heart Disease										
Stroke										
Kidney Disease										
Obesity										
Genetic Disorder										
Alcoholism										
Liver Disease										
Depression or Bipolar Disorder										
Colon or Rectal Cancer										
Breast Cancer										
Other Cancer										
Other: _____										

ALLERGY LIST

Allergies	Type of Reaction

SOCIAL HISTORY

Have you ever used tobacco? ❑ Yes ❑ No If yes: Year started using _____

If yes, indicate the type of tobacco used:

(check all that apply) ❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Snuff/Chew

Are you still using tobacco? ❑ Yes ❑ No If no: Year quit using _____

How often do you drink alcohol? ❑ Never ❑ Daily ❑ Occasional

Do you use illegal drugs? ❑ Yes ❑ No If yes, describe._____

OTHER PHYSICIANS AND PROVIDERS OF CARE

Name & Specialty/Provider Type	Type of Care

ADVANCE DIRECTIVE

Do you have a healthcare Power of Attorney? ❑ Yes ❑ No

If yes, please bring a copy to your visit.

Do you have a living will? ❑ Yes ❑ No

If yes, please bring a copy to your visit.

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HOME SAFETY

When you are prone to falling, your home can either support you or become a reason for your falls. Think about the things you do every day and how you move about in your home to accomplish these things. Then answer the questions below as accurately as you can.

1. In some places in my house, there are things I have to step over (cords, thresholds) or things I have to step around to accomplish the things I need to do. How many of these things are in your home?

❑ **None** ❑ **One or two** ❑ **In a few rooms** ❑ **In almost every room**

2. In some rooms in my home, I have placed heavy furniture (chairs, tables, dressers) so that I can use it to steady myself when I am walking or when I get up:

❑ **Everywhere** ❑ **Most places** ❑ **Sometimes** ❑ **Few things to steady me**

3. Most of the light bulbs in my house are:

❑ **more than 100 watts** ❑ **100 watts** ❑ **60-75 watts** ❑ **40 watts or less** ❑ **I don't know**

4. When I am at home, I wear:

❑ **shoes that fasten** ❑ **shoes that slip on** ❑ **slippers** ❑ **I am barefoot or in socks**

5. To get on and off a low toilet seat, I:

❑ **have no problem** ❑ **have installed a raised seat and/or a grab bar**
❑ **hold on to a towel rack, the sink or the toilet tissue holder**

6. Which of the statements below best describes your bathing?

- ❑ **I take a sponge bath and do not use the tub or shower**
- ❑ **I take a shower and use equipment so that I can sit or can hold on when showering and when getting in and out of the shower.**
- ❑ **I take a bath and use equipment so that I can sit or can hold on when raising/lowering myself in the tub and when stepping into and out of the tub.**
- ❑ **I take a shower, but sometimes feel like I might slip while showering or when I am getting in and out of the shower.**
- ❑ **I take a bath, but sometimes I feel like I might slip while lowering myself into the tub, getting up from the tub or stepping over the side of the tub.**

7. I slip or have difficulty with steps or stairs in my house:

❑ **Never** ❑ **Rarely** ❑ **Sometimes** ❑ **Often**

8. I stand on my toes or use a step-stool to get things out of reach in my kitchen or closets:

❑ **Never** ❑ **Rarely** ❑ **Sometimes** ❑ **Often**

9. When I go outside, I encounter steps, gravel, uneven surfaces or rough ground that sometimes makes me feel unsteady:

❑ **Never** ❑ **Rarely** ❑ **Sometimes** ❑ **Often**

10. If I were to fall and not be able to get up, I could get help by:

- ❑ **Calling out-there are always other people in my home**
- ❑ **Using an emergency alert response unit (pendant/wristband) that I always wear**
- ❑ **Using a cordless phone that I keep with me**
- ❑ **Trying to crawl to a room with a phone or a window where I could call out**
- ❑ **I don't' know what I would do**

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RISK QUESTIONNAIRE

In general, compared to other people your age, would you say that your health is:

❑ Poor ❑ Fair ❑ Good ❑ Very good ❑ Excellent

How much difficulty, <u>on average</u>, do you have with the following physical activities:

	No Difficulty	A Little Difficulty	Some Difficulty	A Lot of Difficulty	Unable to Do
Stooping, crouching or kneeling?	❑	❑	❑	❑	❑
Lifting, or carrying objects as heavy as 10 pounds?	❑	❑	❑	❑	❑
Reaching or extending arms above shoulder level?	❑	❑	❑	❑	❑
Writing, or handling and grasping small objects?	❑	❑	❑	❑	❑
Walking a quarter of a mile?	❑	❑	❑	❑	❑
Heavy housework such as scrubbing floors or washing windows?	❑	❑	❑	❑	❑

Because of your health or a physical condition, do you have any difficulty:

Shopping for personal items (like toilet items or medicines)?	❑ **Yes**	❑ **No**	❑ **Don't Know**
If Yes, do you get help with shopping?	❑ **Yes**	❑ **No**	
If Don't Know, is that because of your health?	❑ **Yes**	❑ **No**	
Managing money (like keeping track of expenses or paying bills)?	❑ **Yes**	❑ **No**	❑ **Don't Know**
If Yes, do you get help with managing money?	❑ **Yes**	❑ **No**	
If Don't Know, is that because of your health?	❑ **Yes**	❑ **No**	
Walking across the room?	❑ **Yes**	❑ **No**	❑ **Don't Know**
If Yes, do you get help with walking?	❑ **Yes**	❑ **No**	
If Don't Know, is that because of your health?	❑ **Yes**	❑ **No**	
Doing light housework (like washing dishes, straightening up, or light cleaning)?	❑ **Yes**	❑ **No**	❑ **Don't Know**
If Yes, do you get help with light housework?	❑ **Yes**	❑ **No**	
If Don't Know, is that because of your health?	❑ **Yes**	❑ **No**	
Bathing or showering?	❑ **Yes**	❑ **No**	❑ **Don't Know**
If Yes, do you get help with bathing or showering?	❑ **Yes**	❑ **No**	
If Don't Know, is that because of your health?	❑ **Yes**	❑ **No**	

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Motor Vehicle Safety		
Do you always fasten your seat belt when you are in the car?	❑ Yes	❑ No
Do you ever drive after drinking, or ride with a driver who has been drinking?	❑ Yes	❑ No

Mood				
Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at All**	**Several Days**	**More Than Half the Days**	**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
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10. If yes to any problems, how difficult have those 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 ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult				

Stress	
How often is stress a problem for you?	❑ Never/rarely ❑ Sometimes ❑ Often ❑ Always
How well do you handle the stress in your life?	❑ I'm usually able to cope effectively ❑ At times I have problems coping ❑ I often have problems coping

Social / Emotional Support	
How often do you get the social and emotional support you need?	❑ Always ❑ Usually ❑ Sometimes ❑ Rarely ❑ Never

Eating Patterns	
Over the past 7 days:	Number of Times
a. How many times a week did you eat fast food or snacks or pizza?	
b. How many servings of fruits/vegetables did you eat each day?	
c. How many soda and sugar sweetened drinks (regular, not diet) did you drink each day?	

Patient Signature: _____ Date: _____

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