Patient Name:_________________________

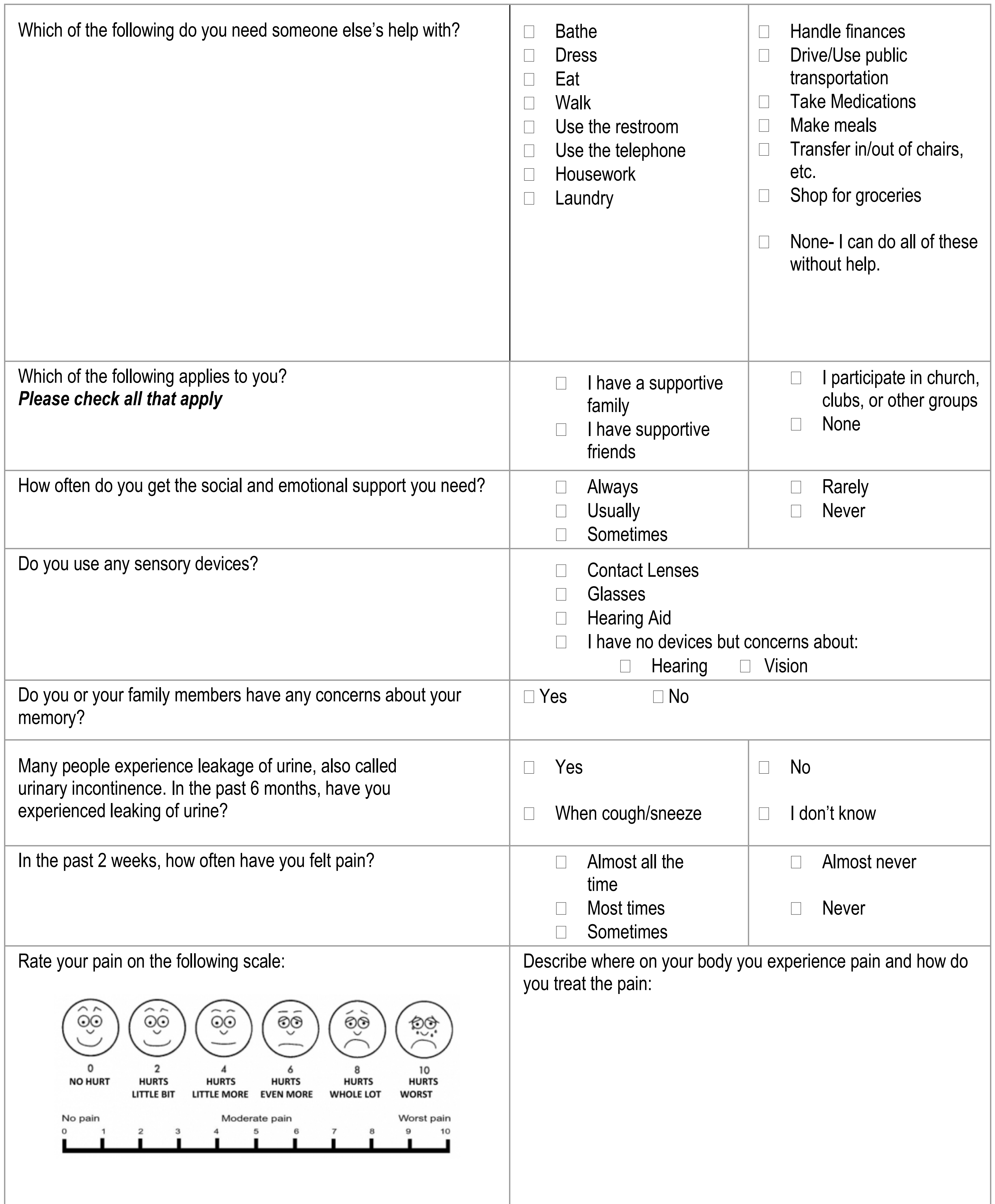
MRN: _______________________________

MEDICARE ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT

Today's Date: _________________________________

Patient Name: _________________________________ Date of Birth: ________________________

What is your primary language spoken at home?	English Spanish Other:
How is your overall health?	Excellent Good Fair Poor
What are your biggest concerns about managing your health? ***Check all that apply***	☐ None – I have not concerns ☐ I live in an unsafe environment ☐ Transportation to appointments ☐ Financial difficulty in paying for services/medicines ☐ I have difficulty taking or remembering my medicines ☐ Difficulty reading or understanding instructions ☐ I am lonely or don't have a lot of support at home ☐ I am often very tired ☐ I experience a lot of stress or anger
What is your housing situation like? ***Check all that apply***	☐ Live with one or more children or dependent ☐ Live with Spouse or Partner ☐ Live in an assisted living facility ☐ Live in a nursing facility ☐ Live alone ☐ I have housing today, but I am worried about losing housing in the future ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) ☐ Lead paint or pipes ☐ Inadequate heat ☐ Oven or stove not working ☐ No (or not working) smoke detectors ☐ Water leaks
Do you feel safe in your home?	☐ Yes ☐ No
Which of the following are in your home?	☐ Throw rugs ☐ Handrails in the bathroom ☐ Proper lighting ☐ Handrails for stairs ☐ No stairs in home



Which of the following do you need someone else's help with?	☐ Bathe ☐ Dress ☐ Eat ☐ Walk ☐ Use the restroom ☐ Use the telephone ☐ Housework ☐ Laundry	☐ Handle finances ☐ Drive/Use public transportation ☐ Take Medications ☐ Make meals ☐ Transfer in/out of chairs, etc. ☐ Shop for groceries ☐ None- I can do all of these without help.
Which of the following applies to you? ***Please check all that apply***	☐ I have a supportive family ☐ I have supportive friends	☐ I participate in church, clubs, or other groups ☐ None
How often do you get the social and emotional support you need?	☐ Always ☐ Usually ☐ Sometimes	☐ Rarely ☐ Never
Do you use any sensory devices?	☐ Contact Lenses ☐ Glasses ☐ Hearing Aid ☐ I have no devices but concerns about: ☐ Hearing ☐ Vision	
Do you or your family members have any concerns about your memory?	☐ Yes ☐ No	
Many people experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experienced leaking of urine?	☐ Yes ☐ When cough/sneeze	☐ No ☐ I don't know
In the past 2 weeks, how often have you felt pain?	☐ Almost all the time ☐ Most times ☐ Sometimes	☐ Almost never ☐ Never
Rate your pain on the following scale: 0 NO HURT · 2 HURTS LITTLE BIT · 4 HURTS LITTLE MORE · 6 HURTS EVEN MORE · 8 HURTS WHOLE LOT · 10 HURTS WORST No pain · Moderate pain · Worst pain 0 1 2 3 4 5 6 7 8 9 10	Describe where on your body you experience pain and how do you treat the pain:	

Which of these assistive devices do you use? ***Please check all that apply***	☐ Cane ☐ Walker ☐ Wheelchair	☐ Crutches ☐ Other ☐ None
Have you fallen in the past year?	☐ Yes – 1 time ☐ Yes- 2 or more times ☐ No- I have not fallen in the past year	
Are you afraid of falling?	☐ Yes	☐ No
If you use any tobacco products, are you interested in quitting?	☐ Yes ☐ No ☐ NA-I don't use tobacco products.	
How many days in a week do you drink alcohol?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7	
How many alcoholic drinks to you have in a typical week?	☐ 0 ☐ 1-2 ☐ 3-6 ☐ 7-10 ☐ 10 or more	
Do you use any illegal drugs?	☐ Yes (please describe): ☐ No	
Do you take any prescription medications that have not been prescribed to you?	☐ Yes (please describe): ☐ No	
Do you fasten your seatbelt in vehicles?	☐ Yes ☐ No ☐ I don't ride in vehicles	
Do you have questions or concerns about your dietary needs or nutrition?	☐ Yes ☐ No	
How many days a week do you exercise?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know	
How intense is your exercise?	☐ Light ☐ Moderate ☐ Heavy ☐ Very Heavy	☐ I don't know ☐ I don't exercise
How many hours of sleep do you usually get?	☐ 0-3 ☐ 4-7 ☐ 8-10 ☐ 10+ ☐ I don't know	
Do you snore, has anyone told you that you snore, or do you currently use a sleep device?	☐ Yes ☐ No ☐ I don't know	
Have you had any problems with your teeth or dentures?	☐ Yes ☐ No	
Are you having any sexual problems you would like to discuss?	☐ Yes ☐ No	

DEPRESSION SCREENING (PHQ-2)				
In the past 2 weeks, how often have you been bothered by the following problems:	**Not at all:**	**Several Days:**	**More than half of those days:**	**Nearly every day:**
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Total Score:				

ADVANCE DIRECTIVES	
Does your family or friends know what you want in an emergency situation or if you could not speak for yourself? ***Check all that apply*** *If you have any of the following, it would be helpful to have a copy provided to us for your medical record.*	☐ No Yes, and I have completed: ☐ A living will (Advance Directive) ☐ Power of Attorney for Health Care ☐ POLST (in some states known as: POST, MOST, MOLST, TPOPP) ☐ Five wishes

Full Name (Please print):	**Relationship to Patient:**
Signature:	**Date:**

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