Patient Name: _____ DOB: _____

Medicare Annual Wellness Health Risk Assessment

Name: _____

Gender: _____ DOB: _____ Phone: _____

Current Height:_____ Current Weight: _____

City: _____

State of Primary Residence: _____ Zip: _____

Race: □ Asian/Pacific □ Black or African American

□ Hispanic □ Native American □ Spanish

□ White □ Other _____

Preferred Language:

□ Spoken_____ □ Written _____

Medical Providers

1.1Do you see any other physicians or medical providers? □ Yes □ No

1.2 If Yes, please list each provider's name and specialty:

_____

_____

Self Assessment

2.1 In general, would you say your health is?

□ Excellent
□ Very Good
□ Good
□ Fair
□ Poor

2.2 Compared to one year ago, your overall health is:□ Better (I'm healthier)
□About the same
□ Not as good (I'm not as healthy)

Medications and Allergies

3.1 In the past 7 days, have you taken all of themedication prescribed to you? □ Yes □ No □ Sometimes*Please bring the medications you are currently taking (if possible), along with a list of these medications, to your doctor's office.*

3.2 Do you have any allergies to medications? If yes, please list:_____

_____

___

3.3 In the past seven days, have you taken any vitamins?

□ Yes □ No □ Sometimes*Please bring all vitamins and over-the-counter medications you are currently taking (if possible), along with a list of these vitamins/medications, to your doctor's office.*

Surgical History

4.1 In the past 10 years, have you had any surgeries?

□ Yes □ No

If yes, list each surgery and the date/year:_____

_____

_____

_____

_____

4.2 Have you ever had an amputation?

□ Yes □ No

If yes, list the type of amputation:_____

_____

Personal Medical History

Patient Name: _____ DOB: _____

5.1Have you been admitted to the hospital two or more times in the last 12 months? If yes, please provide medical reasons for admissions:_____
_____

5.2 Have you used the emergency room two or more times in the last 12 months? If yes, please provide medical reasons:_____
_____

*Please answer Yes/No/Don't Know to the following questions:*5.3 are you currently being treated or have been treated for: Detail/Explain:

A. Heart disease or failure
   □ Yes □ No □Don't Know _____
B. Heart attack or angina
   □ Yes □ No □Don't Know _____
C. Heart surgery
   □ Yes □ No □Don't Know _____
D. Diabetes
   □ Yes □ No □Don't Know _____
E. Stroke
   □ Yes □ No □Don't Know _____
F. High Blood pressure
   □ Yes □ No □Don't Know _____
G. Kidney disease
   □ Yes □ No □Don't Know _____
H. Arthritis
   □ Yes □ No □Don't Know _____
I. Urinary Problems
   □ Yes □ No □Don't Know _____
J. Breathing problems
   □ Yes □ No □Don't Know _____
K. Cancer
   □ Yes □ No □Don't Know _____
L. Circulation problems
   □ Yes □ No □Don't Know _____
M. Stomach/bowel problems
   □ Yes □ No □Don't Know _____
N. Recent hip fracture (last 12 mos.)
   □ Yes □ No □Don't Know _____
O. Parkinson's disease
   □ Yes □ No □Don't Know _____
P. Anxiety or depression
   □ Yes □ No □Don't Know _____
Q. Asthma/pneumonia/lung disease
   □ Yes □ No □Don't Know _____
R. Hepatitis or liver disease
   □ Yes □ No □Don't Know _____

*Please answer Yes/No/Don't Know to the following questions:*5.4 Are you currently being treated for or have you been treated for:Detail/Explain:

A. Chemotherapy for cancer
   □ Yes □ No □Don't Know _____
B. Injections on a regular basis
   □ Yes □ No □Don't Know _____
C. Tube in the nose or abdomen for feeding
   □ Yes □ No □Don't Know _____
D. Tracheostomy
   □ Yes □ No □Don't Know _____
E. Catheter for urine waste
   □ Yes □ No □Don't Know _____
F. Colostomy or other ostomy
   □ Yes □ No □Don't Know _____

5.5 During the last month, have you leaked urine (even a small amount)? □ Yes □ No

5.6 Are there any other aspects of your medical history you believe may be important for your doctors to know?_____
_____
_____

Family Medical History

Patient Name: _____ DOB: _____

*Please answer Yes/No/Don't Know to the following questions:*6.1 Do you have any blood relatives (e.g. Mother, father, siblings, or children) who have been diagnosed with any of the following conditions:

Detailed/Explain:

A. Cardiovascular disease
□ Yes □ No □Don't Know _____
B. High blood pressure
□ Yes □ No □Don't Know _____
C. Heart attack or chest pain
□ Yes □ No □Don't Know _____
D. Heart surgery
□ Yes □ No □Don't Know _____
E. Diabetes
□ Yes □ No □Don't Know _____
F. Stroke
□ Yes □ No □Don't Know _____
G. Kidney disease
□ Yes □ No □Don't Know _____
H. Aneurysm
□ Yes □ No □Don't Know _____
I. Cancer
□ Yes □ No □Don't Know _____
J. Asthma or lung disease
□ Yes □ No □Don't Know _____
K. COPD or asthma
□ Yes □ No □Don't Know _____
L. Depression of anxiety
□ Yes □ No □Don't Know _____
M. Mental health disease
□ Yes □ No □Don't Know _____
N. Heart failure
□ Yes □ No □Don't Know _____
O. Seizures
□ Yes □ No □Don't Know _____
P. Abdominal aortic aneurysm
□ Yes □ No □Don't Know _____
Q. Glaucoma
□ Yes □ No □Don't Know _____

6.2 Are there any other aspects of your family's medical history you believe may be important for your doctor to know?

_____
_____
_____
_____
_____
_____
_____
_____

Vaccinations and Screenings

7.1 Have you had a flu shot this season?
□ Yes □ No
(notes) _____

7.2 Have you had a pneumonia shot?

□ Yes □ No
If yes, when _____

7.3 Have you had a shingles shot?□ Yes □ No
If yes, when _____

7.4 When did you last have a colonoscopy or other test for colorectal cancer?
□ I don't recall
□ within the past year
□ between 1 and 5 years ago
□ between 6 and 10 years ago
□ More than 10 years ago

(Notes) _____

7.5 When was your last visit to a dentist?
□ Within the past six months
□ Between six and 12 months ago

□ More than one year ago(notes)

_____

7.6 How would you describe the condition of your mouth and teeth (including dentures)?□ Excellent □ Fair□ Good □ Poor(notes)_____

____

7.7 When was your last eye exam?
□ Within the past six months
□ Between six and 12 months ago
□ More than one year ago(notes)_____

___

7.8 When was your last routine physical?

_____

FEMALES ONL Y

7.9 When did you have your last mammogram?_____

_____

7.10 When did you have your last Pap test?_____

____

7.11 When was your last bone density test?_____

____

MALES ONLY

7.12 When did you last have a blood test for your prostate? _____

7.13 When was your last bone density test?

_____

Alcohol Use

8.1 In the past 7 days, on how many days did you drink alcohol? _____ Days

8.2 On days when you drank alcohol, how often did you have 4 or more alcoholic drinks on one occasion?
□ Never
□ Once during the week
□ 2-3 times during the week
□ More than 3 times during the week
□Not applicable(notes)_____

_____

Tobacco Use

9.1 What is your history of smoking cigarettes?
□ Current smoker
□ Former smoker
□ Never Smoked

SMOKERS ONLY

9.2 How many years have you smoked or been smoking? _____

9.3 How much do you currently smoke?
□ Less than or equal to one pack per day
□ More than one pack a day, but less than or equal to two packs per day
□Two or more packs per day

Patient Name: _____ DOB: _____

Nutritional Assessment

10.1 In the past seven days, how many servings of fruits and vegetable did you typically eat each day?
□ More than five
□ Three to five
□ Less than Three(notes)_____

10.2 In the past seven days, how many servings of high fiber or grains did you typically eat each day?□ More than five
□ Three to five
□ Less than Three(notes)_____

10.3 In the past seven days, how many servings of high fat food (sweet snacks or desserts) did you typically eat each day?
□ More than two
□ One or Two
□ None(notes)_____

10.4 In the past seven days, how many servings of protein did you typically eat each day?
□ More than two
□ One or Two
□ None(notes)_____

10.5 On a typical day, how many meals do you eat?
□ One
□ Two
□ Three or more

Behavioral and Psychosocial

Call 911 if patient states suicidal intent.

11.1 In the past 2 weeks, how often have you felt little interest or pleasure in doing things?□ Almost all of the time□ Most of the time□ Some of the time □ Almost never

11.2 In the past 2 weeks, how often have you felt down, depressed, or hopeless?□ Almost all of the time□ Most of the time□ Some of the time □ Almost never

(notes)_____

Functional Status Screen (ADL/IADL)

12.1 *Please let me know if you need help or assistance from others by answering Yes, No, or Sometimes:*Showering or bathing □ Yes □ No □ Sometimes
Walking □ Yes □ No □ Sometimes
Dressing yourself □ Yes □ No □ Sometimes
Toileting (transferring to toilet or cleaning oneself)□ Yes □ No □ Sometimes
Shopping □ Yes □ No □ Sometimes
Doing Laundry □ Yes □ No □ Sometimes
Preparing food □ Yes □ No □ Sometimes
Dispensing or taking daily medications □ Yes □ No □ Sometimes
Eating □ Yes □ No □ Sometimes
Housekeeping □ Yes □ No □ Sometimes
Managing bills or finance □ Yes □ No □ Sometimes
Driving □ Yes □ No □ Sometimes

Patient Name: _____ DOB: _____

Pain Assessment

13.1 In the past 7 days, how much pain have you felt?
□ None
□ Some
□ A lot

13.2 How often does pain affect your day-to-day life and activities? □ All the time □ Some of the time□ Only with activity □ Not applicable(notes)_____

_____

Fall Risk and Exercise Assessment

14.1 In the past 7 days, how many days did you exercise? _____Days

14.2 On days when you exercise, for how many minutes did you exercise? _____

14.3 Have you experienced any falls in the past 12 months?
□ Yes □ No

14.4 Do you walk with a cane or a walker?
□ Yes □ No

(notes)_____

Home and Car Safety Questions

15.1 Have your throw rugs been removes or fastened down?
□ Yes □ No

15.2 Are nonslip mats in all bathtubs and showers?
□ Yes □ No

15.3 When in a car, do you wear a seatbelt?
□ Yes □ No □ Sometimes

Hearing Assessment

16.1 Do you feel you have trouble hearing?
□ Yes □ No

16.2 Do you have trouble hearing in loud environments?
□ Yes □ No

16.3 Do you currently have hearing aids (whether you use them or not)?
□ Yes □ No

(notes)_____

Advanced Care Planning

17.1 Have you completed a will?
□ Yes □ No □ Don't remember

17.2 Have you completed a living will?
□ Yes □ No □ Don't remember

17.3 Have you given that will to your physician/caregiver/ family member?
□ Yes □ No □ Don't remember

17.4 Have you discussed your wishes with you family or partner?
□ Yes □ No □ Don't remember

17.5 Have you completed a healthcare power of attorney?
□ Yes □ No □ Don't remember

Patient Name: _____ DOB: _____

The Psychological Assessment- PQH-9 is a reliable and valid measure of depression severity. Test and scoring follows.

Psychological Assessment (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle number for appropriate answer)	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing thing	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 feeling that you are 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 may 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. Thought that you would be better off dead or hurting yourself in some way	0	1	2	3
Scoring 0 +_____ +_____ +_____ **= Total Score _____**				

Consider total score as possible indicator of level of depression.
Circle the appropriate level of depression

1-4	**Minimal depression**	**15-19**	**Moderately severe depression**
5-9	**Mild depression**	**20-27**	**Severe depression**
10-14	**Moderate depression**		

Patient Name: _____ DOB: _____

To be completed at appointment.