Medicare Annual Wellness Health Risk Assessment

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: □ Asian/Pacific □ Black or African American

Gender: \_\_\_\_\_\_ DOB: \_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_ □ Hispanic □ Native American □ Spanish

Current Height:\_\_\_\_\_\_\_ Current Weight: \_\_\_\_\_\_\_\_ □ White □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language:

State of Primary Residence: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_ □ Spoken\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Written \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* 1. 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 the medication 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**

5.1 Have 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:

1. Heart disease or failure

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Heart attack or angina

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Heart surgery

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Diabetes

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Stroke

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. High Blood pressure

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Kidney disease

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Arthritis

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Urinary Problems

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Breathing problems

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Cancer

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Circulation problems

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Stomach/bowel problems

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Recent hip fracture (last 12 mos.)

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Parkinson’s disease

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Anxiety or depression

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Asthma/pneumonia/lung disease

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. 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:

1. Chemotherapy for cancer

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Injections on a regular basis

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Tube in the nose or abdomen for feeding

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Tracheostomy

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Catheter for urine waste

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. 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**

*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:

1. Cardiovascular disease

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. High blood pressure

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Heart attack or chest pain

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Heart surgery

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Diabetes

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Stroke

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Kidney disease

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Aneurysm

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Cancer

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Asthma or lung disease

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. COPD or asthma

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Depression or anxiety

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Mental health disease

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Heart failure

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Seizures

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. Abdominal aortic aneurysm

□ Yes □ No □Don’t Know \_\_\_\_\_\_\_\_\_\_\_\_

1. 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

**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

**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 removed 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

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 |
| 1. Feeling down, depressed or hopeless
 | 0 | 1 | 2 | 3 |
| 1. Trouble falling asleep, staying asleep, or sleeping too much
 | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy
 | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating
 | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself, or feeling that you are a failure or have let yourself or your family down
 | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things such as reading the newspaper or watching television
 | 0 | 1 | 2 | 3 |
| 1. 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 |
| 1. 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** |  |  |

* Yes