Health Risk Assessment for Medicare Annual Wellness Visit

Name:	Date of Birth:

Physical Activity

How many days a week do you exercise?

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+

On days when you exercise, for how long do you usually exercise?

☐ 0-3 minutes ☐ 30-60 minutes ☐ More than 1 hour ☐ I am currently not exercising

How intense is your typical exercise?

☐ Light (stretching or slow walking ☐ Moderate (brisk walking) ☐ Heavy (jogging or swimming) ☐ Very heavy (fast running or stair climbing)

☐ I am currently not exercising

Nutrition

How many servings of fruits and vegetables do you have in a day?

☐ None ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ Unsure

How many servings of meat, fish or other proteins do you have in a day?

☐ 1-2 ☐ 3-4 ☐ 5+ ☐ Unsure

How many servings of fiber or whole grains do you have in a day?

☐ 1-2 ☐ 3-4 ☐ 5+ ☐ Unsure

How many servings of fried or high-fat foods do you have in a day?

☐ 1-2 ☐ 3-4 ☐ 5+ ☐ Unsure

How many servings of sugar sweetened drinks do you have in a day?

☐ 1-2 ☐ 3-4 ☐ 5+ ☐ Unsure

Sun Exposure

Do you protect yourself from the sun when outdoors?

☐ Yes ☐ No ☐ Sometimes

General Well Being

In general, would you say your health is?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Do you take all your medications as prescribed?

☐ Yes ☐ No ☐ Sometimes ☐ Rarely never

In the last six months, how many times were you admitted to the hospital?

☐ None ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ Unsure

Social and Emotional

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

How often is stress/anger a problem for you?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Pain/Fatigue/Sleep

How often do you feel unusually tired?

☐ Never, rarely ☐ Sometimes ☐ Often ☐ Always

Do you have pain that interferes with performing desired activities?

☐ Never, rarely ☐ Sometimes ☐ Often ☐ Always

How many hours of sleep do you usually get?

☐ 0-3 ☐ 4-6 ☐ 7-10 ☐ 10+ ☐ Unsure

Do you snore or has anyone told you that you snore?

☐ Yes ☐ No ☐ Sometimes

In the past 7 days, how often have you felt sleepy during the daytime?

☐ Never, rarely ☐ Sometimes ☐ Often ☐ Always ☐ Unsure

Functional Ability Assessment

Which of the following can you do on your own (please check all that apply):

☐ Shop for groceries ☐ Use the telephone ☐ Housework ☐ Handle finances ☐ Make meals

☐ Drive/use transportation ☐ Take medications

Activities of daily living (check items that you can complete independently):

☐ Bathe ☐ Walk ☐ Dress ☐ Eat ☐ Transfer in/out of chair, etc.

☐ Use the restroom

Fall Risk Assessment and Ambulation Status

Do you (please check all that apply):

☐ Worry about falling

☐ Feel unsteady when standing or walking

☐ Feel dizzy when you get up from a bed or chair

☐ Afraid to leave the house due to dizziness or balance problems

☐ None of these are applicable

How many times have you fallen in the past year?

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+

How long can you walk or move around?

☐ 0-5 minutes ☐ 5-10 minutes ☐ 15-39 minutes ☐ More than 1 hour ☐ Unsure

Which of these assistive devices do you use?

☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ None

Bladder Control Review

Please check all that apply:

☐ Leak urine occasionally, such as when you laugh

☐ Leak urine daily

☐ Treat urinary leakage with bladder exercises

☐ Take a prescription medication for urinary leakage

☐ Received a surgical procedure to help with urinary leakage

☐ I do not have urinary leakage

Hearing and Visual Screening

Hearing - Please check all that apply:

☐ Have problems with hearing

☐ Difficulty hearing the telephone, television, or radio

☐ Others complaining that you turn the TV volume up too high

☐ People you talk to seem to mumble or you request them to repeat themselves

☐ Difficulty hearing in a noisy background

Vision - Please check all that apply:

☐ Difficulty with your vision

☐ Wear contact lenses or eyeglasses

☐ Receive an annual eye exam

Home Safety

What is your living situation?

☐Alone ☐With spouse or another family/roommate ☐Nursing home or assisted living facility

☐I do not have a place to live ☐Other

Please check which items are present in your home:

☐Rugs in the hallways ☐Grab bars in the bathroom ☐Clutter in your walking space at home

☐Handrails on stairs and steps ☐Functioning smoke alarms

Memory Loss and End of Life Planning

Memory Loss - Please check applicable items:

☐Difficulty remembering appointments and dates ☐Family members report that you have difficulty remembering things ☐No known memory issues

End of Life Planning

An Advance Directive, Living Will or Power Attorney for Health Care is a legal document that states your wishes regarding health care if you are unable to speak for yourself.

Please check applicable items:

☐ Advance Directive, Living Will or Power Attorney for Health Care has been completed ☐I would like further information regarding Advance Directives

Biometric Measures - Self Reported

Do you feel your **BLOOD PRESSURE** is?	☐Low or normal (at or below 120/80)	☐Borderline high (120/80 to 139/89)	☐ High (140/90 or higher)	☐ Unsure
Do you feel your **CHOLESTEROL** is?	☐Desirable (below (200)	☐Borderline high (200-239)	☐High (240 or higher)	☐Unsure
Do you feel your **BLOOD GLUCOSE** is?	☐Desirable (below 100)	☐Borderline high (100-125)	☐High (126) or higher	☐Unsure
Do you feel your **hemoglobin A1c** is?	☐Desirable (6 or lower)	☐ Borderline high (7)	High (8)	☐ Unsure

What is your weight: **How tall are you:**