Health Risk Assessment
Medicare Wellness Visit

Patient Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Race: _____ Ethnicity: _____

Care Team

Dentist: _____ Last dental visit: _____

Eye Doctor: _____ Last eye exam: _____

Please list any other providers/doctors involved in your health care (name and specialty):

_____

_____

_____

Do you have any of the following? (mark all that apply):

☐ CPAP/BiPAP ☐ Oxygen ☐ Walker ☐ Wheelchair

Who maintains these? (ex: Lincare, Price Rite): _____

Do you have any concerns with your hearing? ☐ No ☐ Yes

Do you have any concerns with your vision? ☐ No ☐ Yes

Any concerns about your teeth or gums? ☐ No ☐ Yes

Tobacco Use

Have you ever smoked? ☐ No ☐ Yes

If yes, what type? ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Other: _____

If cigarettes, how often do you smoke? ☐ Every day ☐ Some days ☐ Former smoker

If cigarettes, how many years have/did you smoke? _____

If former smoker, when did you quit? _____

If cigarettes, how many packs did you smoke each day: _____

Any e cigarette use? ☐ No ☐ Yes

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes

If yes, what do you drink?_____ and how often_____

Sexual Activity

Are you currently sexually active? ☐ No ☐ Yes

Is your partner / Are your partners: ☐ Male ☐ Female ☐ Both

Advanced Planning/Living Wills/Privacy

Do you have an advance directive? ☐ No ☐ Yes If yes, what type? _____

Daily Living

Do you exercise on a regular basis? ☐ No ☐ Yes

Do you have any specific diet that you follow? ☐ No ☐ Yes

Do you have any difficulties dressing, bathing, or walking? ☐ No ☐ Yes

Do you have any difficulties managing your medications? ☐ No ☐ Yes

Do you have any problems with household chores such as shopping, housekeeping, handling your finances? ☐ No ☐ Yes

Do you have concerns about the safety of your home, stairways without handrails, bathrooms, etc.? ☐ No ☐ Yes

How would you rate your current state of health? ☐ Excellent ☐ Good ☐ Fair

Have you had a fall within the last 3 months? ☐ No ☐ Yes

Can you climb one flight of stairs without help? ☐ No ☐ Yes

Can you walk one block without assistance? ☐ No ☐ Yes

Who prepares your food? _____

Who takes care of your money and/or bills? _____

Pain: How many days per week do you have physical pain that affects your activities?

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+

Sleep:

How many hours of sleep do you usually get per night?

☐ 0-3 ☐ 4-6 ☐ 7-10 ☐ 10+ ☐ I don't know

Nutrition:

How many servings of vegetables do you eat per day?_____

Safety:

Do you wear seatbelts in the car? ☐ No ☐ Yes

Do you feel safe at home? ☐ No ☐ Yes

What is your living situation today? (please check one)

☐ I have a steady place to live

☐ I have a place to live today, but I am worried about losing it in the future

☐ I do not have a steady place to live

Do you have smoke detectors at home? ☐ No ☐ Yes

Do you have carbon monoxide detectors? ☐ No ☐ Yes

Well-being Index (WHO-5)

Over the last 2 weeks:

I have felt cheerful and in good spirits:

☐ All of the time ☐ Most of the time ☐ Less than half of the time ☐ Some of the time ☐ At no time

I have felt calm and relaxed:

☐ All of the time ☐ Most of the time ☐ Less than half of the time ☐ Some of the time ☐ At no time

I have felt active and vigorous:

☐ All of the time ☐ Most of the time ☐ Less than half of the time ☐ Some of the time ☐ At no time

I woke up feeling fresh and rested:

☐ All of the time ☐ Most of the time ☐ Less than half of the time ☐ Some of the time ☐ At no time

My daily life has been filled with things that interest me:

☐ All of the time ☐ Most of the time ☐ Less than half of the time ☐ Some of the time ☐ At no time

Social Determinants of Health Screen

How hard is it for you to pay for the basics like food, housing, medical care, heat?

☐ Hard ☐ Not very hard ☐ Sometimes difficult ☐ Not difficult

In the past year, was there a time when you were not able to pay the mortgage or rent on time?

☐ No ☐ Yes

In the past year, was there a time you did not have a steady place to sleep or slept in a shelter?

☐ No ☐ Yes

Is transportation hard for you? (ex: kept you from work, appointments, or errands)

☐ No ☐ Yes

In the past year, were you worried that your food would run out before you got money to buy more?

☐ Never true ☐ Sometimes true ☐ Often true

On average, how many days per week do you engage in moderate to strenuous exercise such as a brisk walk? (please circle one): 0 1 2 3 4 5 6 7

On average, how many minutes per day do you exercise? _____

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?

☐ Never ☐ Once/week ☐ Twice/week ☐ Three times/week ☐ More

How often do you get together with friends or relatives each week?

☐ Never ☐ Once/week ☐ Twice/week ☐ Three times/week ☐ More

Are there any other worries or concerns you want to discuss with your care provider today?