Medicare Annual Wellness Visit
Health Risk Assessment

Today's Date: _____

Patient Name: _____ DOB: _____

PERSONAL INFORMATION	
What is your primary language spoken at home?	English Spanish Other:
How do you prefer we communicate?	Phone/Text: (#_____-_____-_____) E-mail:
Do you use a local pharmacy?	Yes No Name: Phone Number: (#_____-_____-_____)
GENERAL HEALTH	
How is your overall health?	Excellent Good Fair Poor
What are your biggest concerns about managing your health? ***Check all that apply***	o None o I live in an unsafe environment o Transportation to appointments o Financial difficulty in paying for services/medicines o I have difficulty taking my medicines o Difficult reading or understanding instructions o I am lonely or don't have a lot of support at home o I fall a lot at home
How many times in the last 6 months have you been to the emergency room?	0 1-2 3-4 5+ I don't know
How many times in the last 6 months have you been admitted to the hospital?	0 1-2 3-4 5+ I don't know
Please list any new healthcare providers you have seen since your last visit with us.	
Please list any new medicines you have started since your last visit with us.	
Have you had any problems with your vision?	Yes No
Have you had any problems with your hearing?	Yes No
Do you or your family members have any concerns about your memory?	Yes No

Please list any updates to your Family Medical History (family conditions that your doctor may not know about):	

TOBACCO AND ALCOHOL USE

Do you use any tobacco products? (Cigarettes, chew, snuff, pipes, cigars)	Yes No
If so, are you interested in quitting tobacco?	Yes No I don't use tobacco
On average, how many drinks do you have in a week?	1-2 3-4 5+ I don't drink

DEPRESSION 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:

FUNCTIONAL STATUS ASSESSMENT

Activities of daily living (ADL's) - Please circle those that apply.

Which of the following can you do on your own without help?	Bathe Dress Eat Walk Use the restroom Transfer in/out of chairs, etc. None
Does someone help you at home? If yes, please provide Caregiver Name:	Yes No Spouse Children Other: Aide/Caregiver #:
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

Instrumental activities of daily living (IADL's) - Please circle those that apply.

Which of the following can you do on your own without help?	Shop for groceries Use the telephone Housework Handle finances Drive/Use public transportation Take Medications Make meals None

RISK FOR FALLING

Which of these assistive devices do you use? ***Please circle all that apply***	Cane Walker Wheelchair Crutches Other None
Do you have trouble with your balance?	Yes No
Have you fallen 2 or more times or have had a fall with injury in the past year?	Yes No
Are you afraid of falling?	Yes No
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.*	• Yes, I have a living will • Yes, I have a power of attorney • Yes, I have a MOLST • Yes, I have a POLST • Yes, I have completed 5 wishes • No
Would you like more information?	Yes No Unsure

List of physicians you currently see:

1. 4.

2. 5.

3. 6.

Please list all prescribed medications, strength, and directions you currently take:

1. 9.

2. 10.

3. 11.

4. 12.

5. 13.

6. 14.

7. 15.

8. 16.

Please list all supplements and OTC (over the counter) medication you currently take:

1.

2.

3.

4.

5.

Have you had the following vaccines:

Seasonal Flu	**Yes**	**No**	**Pneumovax 23**	**Yes**	**No**
Prevnar 13	**Yes**	**No**	**Shingles**	**Yes**	**No**
Tdap	**Yes**	**No**			