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Medicare Annual Wellness Visit (AWV)
Health Risk Assessment Questionnaire

This questionnaire is required for all First and Subsequent Annual Wellness Visits (AWV) and is also used for Welcome to Medicare Visits (Initial Preventive Physical Exam or IPPE).

If you have already completed this questionnaire electronically through eCare, please inform the front desk.

Today's Date: _____
Name: Last _____ First _____ MI _____
Date of Birth: _____

Care Providers

Please list all care providers (including specialists, eye doctors, naturopaths, etc.):

Self-Assessment of Health

Please check one response for each:

1. How do you rate your overall health over the past 4 weeks?
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Can you manage your overall health problems?
   ☐ Yes ☐ No
3. Because of health problems, do you need help with personal care needs (eating, bathing, dressing, getting around)?
   ☐ Yes ☐ No
4. Do you often get the emotional support you need?
   ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Psychosocial Health

In the past 2 weeks, how often have you been bothered by:

5. Distress or difficulty getting along with family/friends?
   ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
6. Stress over health, finances, relationships, or work?
   ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
7. Body pain?
   ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
8. Fatigue?
   ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

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Health and Habits

9. In the past 7 days, how many days did you exercise? _____ days
10. On exercise days, how long did you exercise (minutes)? _____ min ☐ Does not apply
11. How intense was your exercise?
    ☐ Light ☐ Moderate ☐ Heavy ☐ Very heavy ☐ Not exercising
12. In the past 7 days, how often did you eat **3+ servings of fruits/vegetables** in a day?
    ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
13. In the past 7 days, how often did you eat **3+ servings of high-fiber/whole grain foods** in a day? _____
    ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
14. Condition of your mouth and teeth (including dentures)?
    ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
15. Do you have trouble hearing people speak? ☐ Yes ☐ No
16. Do you wear a hearing aid/device? ☐ Yes ☐ No
17. Do you always wear a seatbelt in the car? ☐ Yes ☐ No
18. Do you have a fire extinguisher at home? ☐ Yes ☐ No
19. Do you have a smoke detector at home? ☐ Yes ☐ No

Function and Mobility

(In your present state of health, how much difficulty do you have with the following activities?)

20. Preparing food/eating ☐ Independent ☐ Need some help ☐ Cannot do; need assistance
21. Bathing ☐ Independent ☐ Need some help ☐ Cannot do; need assistance
22. Dressing ☐ Independent ☐ Need some help ☐ Cannot do; need assistance
23. Using the toilet ☐ Independent ☐ Need some help ☐ Cannot do; need assistance
24. Moving from place to place ☐ Independent ☐ Need some help ☐ Cannot do; need assistance
25. Devices used (check all that apply):
    ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Built-up chair
    ☐ Utensil/dressing aids ☐ None
26. Have you fallen or nearly fallen in the past year? ☐ Yes ☐ No
27. Are you afraid of falling? ☐ Yes ☐ No
28. Do you have issues with balance/unsteadiness? ☐ Yes ☐ No
29. Do you feel safe in your home environment? ☐ Yes ☐ No
30. Are there home hazards (trip/slip/fall risks)? ☐ Yes ☐ No
31. Do you leak urine or stool? ☐ Yes ☐ No
32. Do you wear pads/liners/undergarments for leakage? ☐ Yes ☐ No

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Daily Living Activities

33. Shopping ☐ Independent ☐ Some help ☐ Cannot do
34. Using the telephone ☐ Independent ☐ Some help ☐ Cannot do
35. Housekeeping ☐ Independent ☐ Some help ☐ Cannot do
36. Laundry ☐ Independent ☐ Some help ☐ Cannot do
37. Driving/transportation ☐ Independent ☐ Some help ☐ Cannot do
38. Managing finances ☐ Independent ☐ Some help ☐ Cannot do
39. Taking medications ☐ Independent ☐ Some help ☐ Cannot do

Memory Concerns

40. Have you experienced memory/thinking problems? ☐ Yes ☐ No
41. Have others expressed concerns about your memory? ☐ Yes ☐ No

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Screening and Preventive Services

(Please note where and when most recently completed)

- Pneumococcal Vaccines: Where _____ When _____
- Influenza Vaccine: Where _____ When _____
- Hepatitis B Vaccine: Where _____ When _____
- Mammogram (Women): Where _____ When _____ Result ☐ Normal ☐ Abnormal ☐ Unsure
- Pap Smear (Women): Where _____ When _____ Result ☐ Normal ☐ Abnormal ☐ Unsure
- Colorectal Screening: Where _____ When _____ Result ☐ Normal ☐ Abnormal ☐ Unsure
- Diabetes Screening: Where _____ When _____ Result ☐ Normal ☐ Abnormal ☐ Unsure
- Cholesterol Panel: Where _____ When _____ Result ☐ Normal ☐ Abnormal ☐ Unsure
- Bone Density: Where _____ When _____ Result ☐ Normal ☐ Abnormal ☐ Unsure
- Eye Exam: Where _____ When _____ Result ☐ Normal ☐ Abnormal ☐ Unsure
- AAA Screening: Where _____ When _____ Result ☐ Normal ☐ Abnormal ☐ Unsure

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Advance Care Planning

42. POLST form ☐ Yes ☐ No ☐ Don't know
43. Living will/Advance Directive ☐ Yes ☐ No ☐ Don't know
44. Durable Power of Attorney for Health Care ☐ Yes ☐ No ☐ Don't know
45. Do you want to discuss advance care planning at this visit?
    ☐ Yes ☐ No ☐ Not sure

☑ **Thank you for completing this questionnaire.**
