**MEDICARE ANNUAL WELLNESS VISIT**

**HEALTH RISK ASSESSMENT QUESTIONNAIRE**

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  | **Provide an answer or circle the appropriate answer:**  |
| **Physical Activity:** |  |
| In the past 7 days, how may days did you exercise? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ days |
|  On days when you exercised, for how long did you exercise?  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ minutes/day |
|  How intense was your typical exercise?  | Light Moderate Heavy Very Heavy Not Exercising |
| **Tobacco User:** |
| In the past 30 days, have you smoked tobacco? | Yes No |
| In the last 30 days, have you used a smokeless tobacco product? | Yes No |
| If Yes to either, would you be interested in quitting tobacco use within the next month?  | Yes No |
| **Alcohol Use:** |
| In the past 7 days, on how many days idd you drink alcohol? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ days |
| On days when you drank alcohol, how often did you have (> 5 for men, >=4 for women or men/women >= 65) drinks at one time?  | Once during the week \_\_\_\_2-3 times during the week \_\_\_\_More than 3 times during the week \_\_\_\_ |
| Do you ever drive after drinking, or ride with a driver who has been drinking?  | Yes No |
| **Nutrition:**  |
| In the past 7 days, how many servings of frutis and vegetables die you typically eat each day? | \_\_\_\_\_\_\_\_\_\_\_\_\_ servings per day |
| In the past 7 days, how many servings of high fiber or whole graine foods did you typically eat each day? | \_\_\_\_\_\_\_\_\_\_\_\_\_ servings per day |
| In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? | \_\_\_\_\_\_\_\_\_\_\_\_\_ servings per day |
| In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?  | \_\_\_\_\_\_ sugar sweetened beverages consumed each day. |
| **Seat Belt Use:** |
| Do you always fasten your seat belt when you are in a car?  | Yes No |
| **Depression:** |
| In the past 2 weeks, how often have you felt down, depressed, or hopeless?  | Almost all the time Most of the Time Some of the time Almost Never |
| In the past 2 weeks, how often have you felt little interest or pleasure in doing things?  | Almost all the time Most of the Time Some of the time Almost Never |
| Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?  | Yes No |
| **Anxiety:** |
| In the past 2 weeks, how often have you felt nervous, anxious, or on edge?  | Almost all the time Most of the Time Some of the time Almost Never |
| In the pat 2 weeks, how often were you not able to stop worrying or control your worrying?  | Almost all the time Most of the Time Some of the time Almost Never |
| **High Stress:**  |
| How often is stress a problem for you in handling your health?  | Never or rarely Sometimes Often Always |
| How often is stress a problem for you in handling your finances? | Never or rarely Sometimes Often Always |
| How often is stress a problem for you in handling your family or social relationships?  | Never or rarely Sometimes Often Always |
| How often is stress a problem for you in handling your work?  | Never or rarely Sometimes Often Always |
| **Social/Emotional Support:**  |
| How often do you get the social and emotional support you need?  | Always Usually Sometimes Rarely Never |
| **Pain:** |
| In the past 7 days, how much pain have you felt?  | Always Usually Sometimes Rarely Never |
| **General Health:**  |
| In general, would you say your health is?  | Excellent Very Good Good Fair Poor |
| How would you describe the condition of your mouth and teeth – including flse teeth or dentures?  | Excellent Very Good Good Fair Poor |
| **Activities of Daily Living:**  |
| In the past 7 days, did you need help from others to perform activities of everyday living? (eating, getting dressed, grooming, bathing, waking, or using the toilet) | Yes No |
| **Instrumental Activities of Daily Living** |
| In the past 7 days, did you need help from others to perform instrumental activities of everyday living? (laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications) | Yes No |
| **Sleep:**  |
| Each night, how many hours of sleep do you usually get?  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hours |
| Do you snore or has anyone told you that you snore?  | Yes No |
| In the past 7 days, how often have you felt sleepy during the daytime?  | Always Usually Sometimes Rarely Never |

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Signature of patient or responsible party Printed Name Date

 **PAST YEAR MEDICAL HISTORY UPDATE**

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any recent hospital visits? \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

If Yes, Hospital Visits in the last 6 months:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reason** | **Hospital** | **Admitted?** | **Date of Hospitalization** | **Surgeries and Procedures** |
|  |  | Yes No  |  |  |
|  |  | Yes No  |  |  |
|  |  | Yes No  |  |  |
|  |  | Yes No  |  |  |

Other Physicians, Therapists, Etc.

|  |  |
| --- | --- |
| **Physician Name & Specialty** | **Reasons for Seeing This Provider** |
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Transplant

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Transplant** | **Transplant Type** | **Transplant Year** | **Dialysis** | **Dialysis Frequency** |
|  Yes No |  |  |  Yes No |  MWF TThS |

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Signature of patient or responsible party Printed Name Date