Health Risk Assessment Form (Medicare Annual Wellness Visit 2020)

Patient Name and DOB: _____ Date: _____

1. Is English your primary language	
If no, what is your primary language?	Spanish Russian Chinese Other
2. How do you rate your overall health?	Excellent Very Good Good Fair Poor
3. Do you have a vision impairment that requires special reading materials?	☐ Yes ☐ No
4. Do you have a hearing impairment that requires special materials?	☐ Yes ☐ No
5. Do you have a Primary Care Provider (PCP)?	☐ Yes ☐ No
6. Do you see any Specialists (cardiologist, oncologist, nephrologist. Etc	☐ Yes ☐ No
7. Do you feel your doctor(s) understands your overall medical needs	☐ Yes ☐ No
8. Do you need to see a doctor in the next 60 days?	☐ Yes ☐ No
If yes, do you already have an appointment?	☐ Yes ☐ No
9. Do you get services from a Regional center that provides care for people with developmental disabilities?	☐ Yes ☐ No
10. If you are a female, are you Pregnant?	☐ Yes ☐ No
11. Have you been to the emergency room 2 or more times in the last 12 months?	☐ Yes ☐ No
12. Have you been admitted to the hospital in the last 12 months?	☐ Yes ☐ No
13. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, ostomy supplies, etc.?	☐ Yes ☐ No
If yes, do you need assistance getting more supplies?	☐ Yes ☐ No
14. Do you smoke or use tobacco products?	☐ Yes ☐ No
If yes, would you like help quitting?	☐ Yes ☐ No
15. Do you use home Oxygen?	☐ Yes ☐ No
16. How many prescription medications do you take each day?	1 2 3 4 5 6 7 8 or more
17. Have you ever been told you have the any of the following health conditions?	
California Children's Services (CCS) condition	☐ Yes ☐ No
Asthma/Lung Problems	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
HIV or AIDS	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No
Seizures	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Medical Therapy Program or Unit (MTP/MPU) condition	☐ Yes ☐ No
If yes to any condition above, do you see a doctor for the condition(s)?	☐ Yes ☐ No
If yes to any condition above, have you had any surgeries for the condition(s	☐ Yes ☐ No
Do you need a referral to a specialist for any of the above conditions?	☐ Yes ☐ No
18. Have you ever been told you have a mental or behavioral health condition such as depression, schizophrenia, or bipolar disorder?	☐ Yes ☐ No
Do you need a referral to see a mental health provider?	☐ Yes ☐ No
19. Would you like more information about how to improve your health or how to stay healthy?	☐ Yes ☐ No

20. Do you need help with any of the following actions

Taking a bath or shower	☐ Yes	☐ No
Going up stairs	☐ Yes	☐ No
Eating	☐ Yes	☐ No
Getting dressed	☐ Yes	☐ No
Brushing teeth, brushing hair, shaving	☐ Yes	☐ No
Making meals or cooking	☐ Yes	☐ No
Getting out of a bed or a chair	☐ Yes	☐ No
Shopping or getting food	☐ Yes	☐ No
Using the toilet	☐ Yes	☐ No
Walking	☐ Yes	☐ No
Washing dishes or clothes	☐ Yes	☐ No
Writing checks or keeping track of money	☐ Yes	☐ No
Getting a ride to the doctor or to see friends	☐ Yes	☐ No
Doing house or yard work	☐ Yes	☐ No
Going out to visit family or friends	☐ Yes	☐ No
Using the phone	☐ Yes	☐ No
Keeping track of appointments	☐ Yes	☐ No
If yes, are you getting all the help you need with these activities?	☐ Yes	☐ No

21. Can you live safely and move easily around your home? ☐ Yes ☐ No

If no, does the place where you live have

Good Lighting	☐ Yes	☐ No
Good Heating	☐ Yes	☐ No
Air Conditioning	☐ Yes	☐ No
Rails for any stairs or ramps	☐ Yes	☐ No
Hot Water	☐ Yes	☐ No
Indoor Toilet	☐ Yes	☐ No
A door to the outside that locks	☐ Yes	☐ No
Stairs to get into your home or stairs inside your homoe	☐ Yes	☐ No
Elevator	☐ Yes	☐ No
Space to use a wheelchair	☐ Yes	☐ No
Clear ways to enter and exit your home	☐ Yes	☐ No

22. How do you think you are managing your health?

Do you need help taking your medications?	☐ Yes	☐ No
Do you need help filling our health forms?	☐ Yes	☐ No
Do you need help answering questions during your doctor visits?	☐ Yes	☐ No

23. Do you have family members or others willing and able to help you when you need it? ☐ Yes ☐ No

24. Do you think your caregiver has a hard time assisting you with all your needs? ☐ Yes ☐ No

25. Are you afraid of anyone or is anyone hurting you? ☐ Yes ☐ No

26. Is anyone using your money without your permission? ☐ Yes ☐ No

27. Have you had any changes in thinking, remembering, or making decisions? ☐ Yes ☐ No

28. Have you fallen in the last month? ☐ Yes ☐ No

Are you afraid of falling? ☐ Yes ☐ No

29. Do you sometimes run out of money to pay for food, rent, bills, and medications? ☐ Yes ☐ No

30. Over the past 30 days, how many days have you felt lonely?

- ☐ None - I never feel lonely
- ☐ Less than 5 days
- ☐ More than half the days (more than 15)
- ☐ Most days - I always feel lonely

31. In the last 6 months, did you and your medical providers talk about how much your prescription medications costs? ☐ Yes ☐ No

List of Medications and Supplements You Take

Name of Medication/Supplement	Strength and Dosage

Other Medical Providers That you See

Doctor's Name	Specialty

Medical Supplies That You Use

Medical Supply	Supply Company

AWV -- Patient Assessment
Alcohol Use Disorders Identification Test

Read questions as written. Record answers carefully. These questions are asked about your use of alcoholic beverages during this past year, for example: beer, wine, vodka, etc....
Code answers in terms of "standard drinks". Your answer is the number in ( ). Place your answer on the line at the right.

1. How often do you have a drink containing alcohol? (0) Never (Skip to Qs 9-10) (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week _____	**6. How often during the last year hae you needed a first drink in the morning to get yourself going after a heavy drinking session?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily _____
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8 or 9 (4) 10 or more _____	**7. How often during the last year have you had a feeling of guilt or remorse after drinking?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily _____
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily _____ Skip to Qs 9-10 if Total Score for Qs 2 and 3 = 0	**8. How often during the last lyear have you been unable to remember what happened the night before because you had been drinking?** (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily _____
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily _____	**9. Have you or someone else been injured as a result of your drinking?** (0) No (2) Yes, but not in the last year (4) Yes, during the last year _____
5. How often during the last year have you failedl to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily _____	**10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?** (0) No (2) Yes, but not in the last year (4) Yes, during the last year _____

Risk Level Intervention AUDIT score *

Zone 1	Alcohol Education 0-7
Zone II	Simple Advice 8-15
Zone III	Simple Advice Plus Brief Counseling and Continued Monitoring 16-19
Zone IV	Referral to Specialist for Diagnostic Evaluation and Treatment 20-40

* The AUDIT cut-off score may vary slightly depending on the country's drinking patterns, the alcohol content of standard drinks, and the nature of the screening program. Clinical judgement should be exercised in cases where the patient's score is not consistent with other evidence, or if the patient has a prior history of alcohol dependence. It may also be instructive to review the patient's responses to individual questions dealing with dependence symptoms (Qs 4,5 & 6) and alcohol-related problems (Qs 9 & 10). Provide the next highest level of intervention to patients who score 2 or more on Qs 4,5 and 6 or 4 on Qs 9 or 10.

Patient Health Questionnaire 9 (PHQ-9)

Name_____Date_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself -- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING _____ + _____ + _____+ _____

= TOTAL SCORE: _____

If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe derpession

Screening Schedule

Patient provided written screening schedule and visit summary ☐ Yes ☐ No

Risk Factors (Circle)

Alzheimer's Disease & Dementia	Heart Failure	Arthritis	Hepatitis (Chronic Viral B&C)
Schizophrenia & Other Psych	Atrial Fibrillation	Asthma	Hyperlipidemia (High Cholesterol)
Cancer (Breast, Colorectal, Lung, Prostate)	Hypertension	Stroke	Ischemic Heart Disease
Chronic Kidney Disease	Osteoporosis	Diabetes	Chronic Obstructive Pulmonary Disease
Autism Spectrum Disorders	Depression	HIV/AIDS	Other _____
Substance Use Disorder	Cognitive Impairment		

RECORD OF TESTS PERFORMED

1. Flu Vaccine Date: _____

2. Pneumonia Vaccine (Prevnar 13) Date: _____

3. Pneumonia Vaccine (Pneumovax 23) Date: _____

4. Most recent BMI Value: _____ Date: _____

5. Most recent BP reading Value: _____ Date: _____

6. HbA1C for Diabetic Patients Value: _____ Date: _____

7. LDL-C Value for Diabetic Patients Value: _____ Date: _____

8. Dilated or Retinal Eye Exam for Diabetic Patients Date: _____

9. Mammogram Date: _____

10. Colonoscopy/Sigmoidoscopy Date: _____

11. FOBT or FIT-DNA Date: _____

12. Alcohol Test (AUDIT) or AUDIT Value: _____ Date: _____

13. Index Date PHQ-9 Value: _____ Date: _____

14. Follow-Up PHQ-9 (11-13 Months after Index Date PHQ-9) Date: _____