Medicare Annual Wellness Visit Health Risk Assessment

Today's Date: _____

Patient Name: _____

PERSONAL INFORMATION	
What is your primary language spoken at home?	English ◯ Spanish ◯ Other:
How do you prefer we communicate? **Email** ◯ **Home Phone** ◯ **Mobile Phone** ◯ **Mail** ◯ **Work Phone** ◯	Phone/Text: (# ___ - ___ - ___) E-mail:
GENERAL HEALTH	
How is your overall health?	Excellent ◯ Good ◯ Fair ◯ Poor ◯
What are your biggest concerns about managing your health? ***Check all that apply***	☐ None ☐ I live in an unsafe environment ☐ Transportation to appointments ☐ Financial difficulty in paying for services/medicines ☐ I have difficulty taking my medicines ☐ Difficult reading or understanding instructions ☐ I am lonely or don't have a lot of support at home ☐ 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.	None ☐ Other (please list):
Please list any new medicines you have started since your last visit with us.	None ☐ Other (please list on last page)
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):	None ☐ Other (please list):
TOBACCO AND ALCOHOL USE	
Do you use any tobacco products? (Cigarettes, chew, snuff, pipes, cigars, e-cigarettes, vaping)	Yes ◯ No ◯
If so, are you interested in quitting tobacco?	Yes ◯ No ◯ I don't use tobacco ◯
How many times in the past year have you had 4 or more drinks in a day?	1-2 ◯ 3-4 ◯ 5+ I don't drink ◯

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 check box to right of 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 check the box to the right of 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 POLST ☐ • Yes, I have completed 5 wishes ☐ • No ☐
Would you like more information?	Yes ○ No ○ Unsure ○

DEPRESSION PHQ-9

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**
Trouble falling or staying asleep or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself, or that you're a failure, or have let yourself or family down	**0**	**1**	**2**	**3**
Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you've been moving around a lot more than usual	**0**	**1**	**2**	**3**
Thoughts that you would be better off dead, or of hurting yourself	**0**	**1**	**2**	**3**
Total Score:				
If you checked off any of the problems in this section, 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 at all	Somewhat	Very difficult	Extremely difficult

Personal Medical History		
Congestive Heart Failure	Yes	No
Diabetes	Yes	No
COPD (Chronic Lung Disease) or Asthma	Yes	No
Hypertension	Yes	No
Stroke	Yes	No
Kidney Disease	Yes	No
Obesity	Yes	No
Liver Disease	Yes	No
Bipolar Disorder or Schizophrenia	Yes	No
Dementia	Yes	No
Cancer	Yes	No
Depression	Yes	No

MEDICATIONS – Prescriptions, Vitamins, Over-the-Counter

If you are on any new medications since your last visit please list them below.

Name	Dose	Date Started	Condition Treating