



20311 Lappans Rd, ste 100

Boonsboro, MD 21713

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PVPCOffice@pleasantvalleyprimarycare.com

## MEDICARE VISIT HEALTH RISK ASSESSMENT

(FOR ANNUAL AND SUBSEQUENT WELL VISITS ONLY)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete this checklist before seeing your doctor or nurse. Your response will help you receive the Best health and health care possible.

**1. What is your age?**

- ☐ Under 65
- ☐ 65-69
- ☐ 70-79
- ☐ 80 or older

**2. Are you a male or female?**

- ☐ Male
- ☐ Female

**3. During the *past four weeks*, how much have you been bothered by emotional problems, such as feeling anxious, depressed, irritable, sad or downhearted and blue?**

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

**4. During the *past four weeks*, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?**

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

**5. During the past four weeks, how much bodily pain have you generally had?**

- ☐ No pain
- ☐ Very mild pain
- ☐ Mild pain
- ☐ Moderate pain
- ☐ Severe pain

**6. During the *past four weeks*, was someone available to help you if you needed and wanted help?**

(For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

- ☐ Yes, as much as I wanted
- ☐ Yes, quite a bit
- ☐ Yes, some
- ☐ Yes, a little
- ☐ No, not at all

**7. During the *past four weeks*, what was the hardest physical activity you could do for at least two minutes?**

- ☐ Very heavy
- ☐ Heavy
- ☐ Moderate
- ☐ Light
- ☐ Very Light



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8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)

- ☐ Yes  
☐ No

9. Can you go shopping for groceries or clothes without someone's help?

- ☐ Yes  
☐ No

10. Can you prepare your own meals?

- ☐ Yes  
☐ No

11. Can you do your housework without help?

- ☐ Yes  
☐ No

12. Because of any health problems, do you need the help of another person with your personal care needs, such as eating, bathing, dressing, or getting around the house?

- ☐ Yes  
☐ No

13. Can you handle your own money without help?

- ☐ Yes  
☐ No

14. During the past four weeks, how would you rate your health in general?

- ☐ Excellent  
☐ Very good  
☐ Good  
☐ Fair

15. How have things been going for you *during the past four weeks*?

- ☐ Very well; could hardly be better  
☐ Pretty well  
☐ Good and bad parts about equal Pretty bad  
☐ Very bad; could hardly be worse

16. Are you having difficulties driving your car?

- ☐ Yes, often  
☐ Sometimes  
☐ No  
☐ Not applicable, I do not use a car

17. Do you always fasten your seatbelt when you are in a car?

- ☐ Yes, usually  
☐ Yes, sometimes  
☐ No

18. How often during the *past four weeks* have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up					
Sexual Problems					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					
Tiredness or fatigue					



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**19. Have you fallen two or more times in the past year?**

- ☐ Yes
- ☐ No

**20. Are you afraid of falling?**

- ☐ Yes
- ☐ No

**21. Are you a smoker?**

- ☐ No
- ☐ Yes, and I might quit
- ☐ Yes, but I'm not ready to quit

**Provider Name:** \_\_\_\_\_

**Provider sig:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**22. During the *past four weeks*, how many drinks of wine, beer, or other alcoholic beverages did you have?**

- ☐ 10 or more drinks per week
- ☐ 6-9 drinks per week
- ☐ 2-5 drinks per week
- ☐ 1 drink or less per week
- ☐ No alcohol at all

**The contents in this Form have been reviewed at the Medicare Visit appointment.**

Comments:

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