



2020 PATIENT ASSESSMENT REQUIREMENTS

NEW RULES for 2020

1. As of 2020 ALL insurance companies including Medicare and Medicaid now require their patients to complete a short assessment series annually.
2. Failure to do so will create financial penalties for the physician.
3. We need you to complete these ASAP or some access to patient services such as prescription refills and other orders may be delayed.
4. There is no cost to the patient, as no deductible or copay is required. Thank you for your cooperation.

Thank you in advance!

Date: Time: Existing Patient _____ New Patient _____

Patient Name: Gender _____

Patient Address

Patient DOB:

Patient Mobile Number: Patient Email Address:

Patient Home Number:

List Current Medications: N/A – On file

List any chief complaints or health problems:

Health Risk Assessment (HRA)

1. Physical Activity

In the past 7 days, how many days did you exercise?
____ days

2. Tobacco Use

In the last 30 days, have you used tobacco in any form?
____ Yes
____ No

3. Alcohol Use

In the past 7 days, how many drinks have you had that contain alcohol?
____ Drinks

4. Seat Belt Use

Do you always fasten your seat belt when you are in a car?
____ Yes
____ No

5. Life satisfaction

In the past 2 weeks, how often have you felt down, depressed, or hopeless?
____ Almost all of the time
____ Most of the time
____ Some of the time
____ Almost never

6. Anxiety

In the past 2 weeks, how often have you felt nervous, anxious, or on edge?
____ Almost all of the time
____ Most of the time
____ Some of the time
____ Almost never

7. Stress

How often is stress a problem for you in handling such things such as health, finances, family or social relationships or work?

- ☐ Never or rarely
☐ Sometimes
☐ Often
☐ Always

8. Pain

In the past 7 days, how much pain have you felt?

- ☐ None
☐ Some
☐ A lot

9. General Health

In general, would you say your health is

- ☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

10. Sleep

Each night, how many hours of sleep do you usually get?

- ☐ Hours

11. Blood Pressure

If your blood pressure was checked within the past year, what was it when it was last checked?

- ☐ Low or normal (at or below 120/80)
☐ Borderline high (120/80 to 139/89)
☐ High (140/90 or higher)
☐ Don't know/not sure

12. Cholesterol

If your cholesterol was checked within the past year, what was your total cholesterol when it was last checked?

- ☐ Desirable (below 200)
☐ Borderline high (200–239)
☐ High (240 or higher)
☐ Don't know/not sure

13. Blood Glucose

If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?

- ☐ Desirable (below 100)
☐ Borderline high (100–125)
☐ High (126 or higher)
☐ Don't know/not sure

14. Hemoglobin A1c level

If diabetic, and if you have had your hemoglobin A1c level checked in the past year, what was it the last time you had it checked?

- ☐ Desirable (6 or lower)
☐ Borderline high (7)
☐ High (8 or higher)
☐ Not a Diabetic

15. Overweight/Obesity

What is your height?

Feet Inches Weight in pounds

Annual Wellness Questions

1. Please list all doctors that you have seen in the past year and the specialty
2. Please list all any medications you are currently taking **N/A – On file**
3. Please list any tests you have done in the past year such as blood tests, colonoscopy, mammograms, CT Scan, MRI, etc
4. Have you had any recent immunizations?
Yes_____ No_____
5. Do you have a living will or advance directive?
Yes_____ No_____
6. Can you get places out of walking distance without help? *For example, can you travel alone by bus, taxi, or drive your own car?
Yes_____ No_____
7. Can you shop for groceries or clothes without help?
Yes_____ No_____
8. Can you prepare your own meals?
Yes_____ No_____
9. Can you do your own housework without help?
Yes_____ No_____
10. Can you handle your own money without help?
Yes_____ No_____
11. Do you need help eating, bathing, dressing, or getting around your home?
Yes_____ No_____
12. Have you been given any information to help you keep track of your medications?
Yes_____ No_____
13. Have you been given any information to help you identify hazards in your house that might hurt you?
Yes_____ No_____

14. Have you fallen two (2) or more times in the past year?

Yes_____ No_____

15. How often in the past 4 weeks, have you had problems using the telephone?

Never_____ Seldom_____ Sometimes_____ Often_____

16. How often in the past 4 weeks, have you had trouble eating well?

Never_____ Seldom_____ Sometimes_____ Often_____

17. How often in the past 4 weeks, have you been bothered by your teeth or dentures?

Never_____ Seldom_____ Sometimes_____ Often_____

18. During the past 4 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_____

19. Are you having difficulties driving your car?

No_____ Sometimes_____ yes, Often_____ Not applicable, I do not use a car

20. How confident are you that you can control and manage most of your health problems?

Very Confident_____ Somewhat Confident_____ Not very confident_____ I do not have any health problems_____

21. How often do you have trouble taking medicines the way you have been told to take them?

I do not have to take medicine_____ I always take them as prescribed_____
Sometimes I take them as prescribed_____ I seldom take them as prescribed_____

22. Do any family members have a personal history with any health issues, please list below.

Generalized Anxiety (GAD7)

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious or on edge?

Not at all_____ Several days_____ More than half the days_____ Nearly every day_____

2. Not being able to stop or control worrying?

Not at all_____ Several days_____ More than half the days_____ Nearly every day_____

3. Worrying too much about different things?

Not at all_____ Several days_____ More than half the days_____ Nearly every day_____

4. Trouble relaxing?

Not at all_____ Several days_____ More than half the days_____ Nearly every day_____

5. Being so restless that it is hard to sit still?

Not at all_____ Several days_____ More than half the days_____ Nearly every day_____

6. Becoming easily annoyed or irritable?

Not at all _____ Several days _____ More than half the days _____ Nearly every day _____

7. Feeling afraid as if something awful might happen?

Not at all _____ Several days _____ More than half the days _____ Nearly every day _____

PHQ9

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things

___Not at all ___Several days ___More than half the days ___Nearly every day

2. Feeling down, depressed or hopeless

___Not at all ___Several days ___More than half the days ___Nearly every day

3. Trouble falling asleep, staying asleep, or sleeping too much

___Not at all ___Several days ___More than half the days ___Nearly every day

4. Feeling tired or having little energy

___Not at all ___Several days ___More than half the days ___Nearly every day

5. Poor appetite or overeating

___Not at all ___Several days ___More than half the days ___Nearly every day

6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down

___Not at all ___Several days ___More than half the days ___Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

___Not at all ___Several days ___More than half the days ___Nearly every day

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

___Not at all ___Several days ___More than half the days ___Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way

___Not at all ___Several days ___More than half the days ___Nearly every day