

Medicare Annual Wellness Visit Health Risk Assessment

NAME: _____ **DOB:** _____

A. Social History

- Do you smoke?..... No Yes If Yes, packs/day? _____
 Do you drink alcohol?..... No Yes If Yes, drinks/week? _____
 Do you use illicit drugs?..... No Yes If Yes, type? _____
 Are you sexually active?.... No Yes

B. Depression Screening

1. In the past 2 weeks, how often have you felt little interest or pleasure in doing things?
 Not at all Several days More than half of the days Nearly every day
2. In the past 2 weeks, how often have you felt down, depressed or hopeless?
 Not at all Several days More than half of the days Nearly every day

C. Medical/Surgical History

3. Do you have any **new medical problems** diagnosed since your last annual visit? No Yes
 If YES, list here..... _____
4. Have you had any **surgical procedures** since your last annual visit? No Yes
 If YES, list here..... _____

D. Health Assessment

5. In general, how would you say that your health is:
 Excellent Very Good Good Fair Poor
6. In the **past seven days**, have you experienced any of the following?
 None New or increased pain New or increased fatigue Loneliness
 Social Isolation Stress Anger

E. Advanced Care Planning

7. Do you have a Durable Power of Attorney? No Yes
8. Do you have a Living Will No Yes
9. Do you have other Advanced Care Planning documents? No Yes

(Please turn form over to complete)

Medicare Health Risk Assessment (cont.)

F. Health Habits

10. Do you **exercise** for at least 20 minutes 2-3 times per week?..... No Yes
11. Have you **lost any weight *without trying*** in the past 3 months? No Yes
12. Do you **eat *fewer than 2 meals*** per day? No Yes
13. Has it been over 1 year since you last saw the **dentist**? No Yes
14. Do you or your family notice any trouble with your **hearing**? No Yes

If **YES** do you have hearing aids? _____

15. Do you have difficulty driving, watching TV, reading, or doing any of your daily activities because of your **eyesight**? No Yes

If **YES** do you wear corrective lenses? _____

G. Safety

16. Does your home have **unfastened rugs** or **poor lighting**? No Yes
17. Do you ever ride in the car *without* fastening your **seatbelt**? No Yes

H. Activities of Daily Living

18. In the past 7 days, did you need help to perform any of the following everyday activities?

None Eating Dressing Grooming
 Bathing Toileting Walking/Balance

19. In the past 7 days, did you need help from others to take care of any of the following?

None Laundry Housekeeping Banking/Finance Shopping
 Telephone Use Food Prep Transportation Taking Medication

If **YES** to any of the above, do you have a caregiver, home health, reside in an assisted living or nursing facility? _____

I. Falls Risk Screening

20. Have you **fallen 2 or more times** in the past year? No Yes
21. Have you had any **fall with injury** in the past year? No Yes

J. Immunizations

22. Have you received any immunizations outside of our health system since your last annual visit? No Yes

If **YES** list vaccine and date given: _____