Medicare Preventive, Annual Wellness Visit Health Risk Assessment

Date: _____ **Date of Birth:** _____

Name: _____ **Preferred Pronouns (optional):** _____

General Health	
Form completed by:	☐ Self ☐ Friend/Family ☐ Clinic Staff ☐ Other
How do you rate your overall health?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Rate your pain on a scale on 0-10, where 0 means no pain at all and 10 means the worst pain imaginable.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Do you use opioids to control your pain? (Examples: morphine, methadone, oxycodone)	☐ Yes ☐ No If yes, would you like to try other pain management alternatives? ☐ Yes ☐ No
Do you have any allergies? (Medication, Food, Animal, Other)	☐ Yes ☐ No Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____
Please list your Medications (include dose strength and frequency).	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
Do you feel that a hearing difficulty limits your life?	☐ Yes ☐ No
Do you feel that a vision difficulty limits your life?	☐ Yes ☐ No

How do you rate your oral health? (teeth, gums, dentures)	☐ Excellent ☐ Good ☐ Fair ☐ Poor

Your Medical History *(check if you have had any of the following conditions)*

☐ Allergies ☐ Anemia ☐ Angina ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Atrial Fibrillation ☐ Autoimmune Disease ☐ Blood Clots ☐ Cancer Cancer Type: _____ ☐ Cardiac Arrythmias	☐ COPD ☐ Coronary Artery Disease ☐ Depression ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ High Cholesterol ☐ Statin Therapy (simvastatin, rosuvastatin, atorvastatin) ☐ Gallbladder Disease ☐ GERD (Acid Reflex) ☐ Headache/Migraines ☐ Heart Disease ☐ Statin Therapy ☐ Heart Valve Disorder ☐ Hepatitis/Liver Disease	☐ Hypertension ☐ Irritable Bowel Disease ☐ Myocardial Infarction (Heart Attack) ☐ Osteoporosis ☐ Renal Disease ☐ Seizure Disorder ☐ Stroke ☐ Thyroid Disease ☐ Tuberculosis ☐ Chronic Pain ☐ Opioid Use ☐ Other: _____

Past Surgeries/Recent Hospitalizations *(include emergency room and urgent care visits)*

Tobacco/Vaping Use Screening

Have you ever used tobacco?	☐ Yes ☐ No
Have you used tobacco in the last 30 days?	☐ Yes ☐ No
What type of tobacco have you used?	☐ Cigarettes/Cigars ☐ Pipe ☐ Chew ☐ Smokeless ☐ Snuff
Have you ever tried to quit using tobacco?	☐ Yes ☐ No
Do you vape?	☐ Yes ☐ No If yes, what device? _____ How often? _____
Have you ever had passive smoke or vaping exposure?	☐ Yes ☐ No

Alcohol Screening/CAGE	
Do you drink alcohol?	☐ Yes ☐ No ☐ Former Quit Date: _____
What type of alcohol?	☐ Beer & Liquor ☐ Beer & Wine ☐ Beer ☐ Hard Liquor ☐ Wine ☐ Other: _____
Frequency?	☐ Daily ☐ Occasionally ☐ Rarely ☐ Socially ☐ Other
Amount?	☐ ____ beer(s) ☐ ____ glass(es) ☐ ____ pack(s) ☐ ____ pints/bottles
How many times in the past year, have you had 4 or more drinks in a day?	☐ None ☐ 1-2 ☐ 3-5 ☐ > 5
Have you ever felt the need to cut down on drinking?	☐ Yes ☐ No
Ever felt annoyed by criticism of drinking?	☐ Yes ☐ No
Had guilt feelings about drinking?	☐ Yes ☐ No
Ever taken morning eye opener?	☐ Yes ☐ No
Physical Activity and Lifestyle	
What is your activity level?	☐ Sedentary ☐ Moderate ☐ Vigorous
Are you a health club member?	☐ Now ☐ Previously ☐ Never
What type of exercise do you do?	☐ Type: _____ ☐ I don't exercise
How often do you exercise?	☐ Daily ☐ 2-3x/week ☐ 4-5x/week ☐ Never
Are you sexually active?	☐ Yes ☐ No ☐ Previously
Fall Risk	
Have you had any problems with balance or walking in the last year?	☐ Yes ☐ No
Have you had more than one fall in the last year?	☐ Yes ☐ No If yes, number of falls: _____
Have you had an injury from a fall in the last year?	☐ Yes ☐ No
Home & Safety	
Do you have smoke detectors in your home?	☐ Yes ☐ No

Do you have firearms in the home?	☐ Yes ☐ No If yes: Locked storage? ☐ Yes ☐ No Trigger guard? ☐ Yes ☐ No Ammunition stored separately? ☐ Yes ☐ No Unloaded for storage? ☐ Yes ☐ No Used for: ☐ Recreation ☐ Occupation ☐ Hunting ☐ Protection
Do you use a seatbelt when in a vehicle?	☐ Yes ☐ No
Do you have carbon monoxide detectors in your home?	☐ Yes ☐ No
Do you have heat in your home?	☐ Yes ☐ No If yes, what type? _____

Your Family's Medical History *(list the conditions your family has/had)*

☐ Unknown/Adopted ☐ No relevant family history	☐ Alzheimer's or Dementia ☐ Asthma ☐ Cancer type: _____ ☐ Cardiovascular Disease ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Other Please explain: _____ ☐ Storke

Psychosocial Health (Depression Screening)

Recently, have you felt down, depressed, or hopeless?	☐ Yes ☐ No
Recently, have you felt little interest or pleasure in doing things?	☐ Yes ☐ No
Are you basically satisfied with your life?	☐ Yes ☐ No
Have you dropped many of your activities and interests?	☐ Yes ☐ No
Do you feel that life is empty?	☐ Yes ☐ No
Do you often get bored?	☐ Yes ☐ No
Are you in good spirits most of the time?	☐ Yes ☐ No

Are you afraid that something bad is going to happen to you?	☐ Yes ☐ No
Do you feel happy most of the time?	☐ Yes ☐ No
Do you feel helpless?	☐ Yes ☐ No
Do you prefer to stay home, rather than going out and doing new things?	☐ Yes ☐ No
Do you feel you have more problems with memory than most?	☐ Yes ☐ No
Do you think it is wonderful to be alive now?	☐ Yes ☐ No
Do you feel worthless the way you are now?	☐ Yes ☐ No
Do you feel full of energy?	☐ Yes ☐ No
Do you feel that your situation is hopeless?	☐ Yes ☐ No
Do you think that most people are better off than you are?	☐ Yes ☐ No

Functional Assessment			
Are you able to climb stairs?	☐ Able to	☐ It is difficult	☐ Not able to
Are you able to exercise?	☐ Able to	☐ It is difficult	☐ Not able to
Are you able to get in and out of cars?	☐ Able to	☐ It is difficult	☐ Not able to
Are you able to go down stairs?	☐ Able to	☐ It is difficult	☐ Not able to
Are you able to go up stairs?	☐ Able to	☐ It is difficult	☐ Not able to
Are you able to kneel?	☐ Able to	☐ It is difficult	☐ Not able to
Are you able to perform activities of daily living? (feed, dress, toilet, bathe)	☐ Able to	☐ It is difficult	☐ Not able to
Are you able to put on socks and shoes?	☐ Able to	☐ It is difficult	☐ Not able to
Are you able to walk?	☐ Able to	☐ It is difficult	☐ Not able to
Are you able to walk 10 blocks?	☐ Able to	☐ It is difficult	☐ Not able to
Are you able to walk an unlimited distance?	☐ Able to	☐ It is difficult	☐ Not able to
Are you able to walk 5 to 10 blocks?	☐ Able to	☐ It is difficult	☐ Not able to

Medical Equipment	
Do you use special devices to dress?	☐ Yes ☐ No
Do you use a special or built-up chair?	☐ Yes ☐ No
Do you use special or built-up utensils?	☐ Yes ☐ No
Do you use a cane?	☐ Yes ☐ No
Do you use a walker?	☐ Yes ☐ No
Do you use crutches?	☐ Yes ☐ No
Do you use a wheelchair?	☐ Yes ☐ No
Do you use oxygen?	☐ Yes ☐ No

Nutritional Health	
Have you had unintentional weight gain?	☐ Yes ☐ No If yes, how much? _____
Have you had unintentional weight loss?	☐ Yes ☐ No If yes, how much? _____
How do you get your daily calcium?	☐ Diet ☐ Supplements: _____ mg/day
Do you take a multivitamin?	☐ Yes ☐ No ☐ Occasionally
How do you get your daily Vitamin D?	☐ Diet ☐ Adequate Sunlight Exposure? ☐ No
Do you take folic acid?	☐ Yes ☐ No ☐ Occasionally
Do you have adequate access to water to stay hydrated?	☐ Yes ☐ No

Domestic/Intimate Partner Violence	
Within the past year, or since you have been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?	☐ Yes ☐ No
Are you in a relationship with a person who threatens or physically hurts you?	☐ Yes ☐ No
Has anyone forced you to have sexual activities that made you feel uncomfortable?	☐ Yes ☐ No

Women: Cervical Cancer Screening *(ages 18+)*

Have you had a pap smear and/or HPV test in the past 3 years?	☐ Yes ☐ No ☐ Not sure Date: _____ Location: _____
Colorectal Cancer Screening *(all patients, ages 45+)*	
Have you had a fecal immunochemical (FIT) test in the last year? (FIT test: detects for human blood in your stool sample)	☐ Yes ☐ No Date: _____ Location: _____
Have you had a colonoscopy in the last 10 years?	☐ Yes ☐ No ☐ Not sure Date: _____ Location: _____
Women: Breast Cancer Screening *(ages 40+)*	
Have you had a mammogram within the last year?	☐ Yes ☐ No ☐ Not sure Date: _____ Location: _____
Men: Prostate Cancer Screening *(ages 45+)*	
Have you ever had a prostate specific antigen (PSA) blood test or digital rectal exam?	☐ Yes ☐ No ☐ Not sure Date: _____ Location: _____

Other Health Care Providers *(include dentist)*

Provider Name	Specialty