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| --- |
|  Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

 **Annual Medicare Wellness Visit**

*Health Risk Assessment*

**Physical Activity Tobacco Use**

In the past 7 days how many days did you exercise? In the past 30 days, have you used tobacco?

 \_\_\_\_\_\_\_\_\_\_\_\_ days □ Yes □ No

On days when you exercised, how long did you exercise (in minutes)? Used a smokeless Tobacco product:

\_\_\_\_\_\_\_\_\_\_\_ minutes per day OR □ Does not apply □ Yes □ No

How intense was your typical exercise? If **yes** to either above:

□ Light (like stretching or slow walking) would you be interested in quitting in the

□ Moderate (like brisk walking) next month?

□ Heavy (like jogging or swimming) □ Yes □ No

□ Very Heavy (like fast running or stair climbing) **Seat Belt**

□ I’m currently not exercising Do you always fasten your seat belt when

 you are in a car? **Alcohol Use** □ Yes □ No

In the past 7 days, how many days did you drink alcohol?

\_\_\_\_\_\_\_\_\_\_ days **Depression**

 In the past 2 weeks, how often have you felt

On days when you drank alcohol, how often did you have ( 5 or more for men, down, depressed, or hopeless?

 4 or more for women and those men and women 65 years old or over) □ Almost all of the time

alcoholic drinks on one occasion? □ Most of the time

□ Never □ Some of the time

□ Once during the week □ Almost Never

□ 2-3 times during the week

□ More than 3 time during the week In the past 2 weeks, how often have you felt

 little interest or pleasure in doing things?

Do you ever drive after drinking, or ride with a driver who has been drinking? **□** Almost all of the time

 □ Yes □ No **□** Most of the time

 **□** Some of the time

**Nutrition □** Almost Never

In the past 7 days, how many serving of fruits and vegetables did you

typically eat each day? (1serving= 1 cup of fresh veg., ½ cup of cooked Have your feelings caused you distress or

Veg., or 1 medium piece of fruit. 1 cup= size of baseball) interfered with your ability to get along

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ serving per day socially with friends or family?

 □ Yes □ No

In the past 7 days, how many servings of high fiber or whole grain foods

did you typically eat each day? (1serving= 1 slice of 100% whole wheat  **Pain**

bread, 1 cup of whole grain or high fiber ready to eat cereal, ½ cup of In the past 7 days, how much pain have you

cooked cereal such as oatmeal, or ½ cup of cooked brown rice or wheat felt?

pasta.) □ None

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ serving per day □ Some

 □ A lot

In the past 7 days how may serving of fried or high fat food did you

typically eat each day? (ex: fried chicken, fried fish, bacon, fries, potato

chips, corn chips, doughnuts, creamy salad dressing, whole milk, cream

cheese, or mayo)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ serving per day

**Nutrition -***continued* **Anxiety**

In the past 7 days how many sugar sweetened (not diet) beverages In the 2 weeks, how often were you not

did you typically consume each day? able to stop worrying or control your

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ sugar sweetened beverages consumed each day worrying?

 **□** Almost all of the time

**High Stress □** Most of the time

How often is stress a problem for you in handing such things as? **□** Some of the time

* Your health? **□** Almost Never
* Your finances?
* Your family or social relationships?
* Your work? In the past 2 weeks, how often have you

□ Never or rarely felt nervous, anxious, or on edge?

□ Sometimes □ Almost all the time

□ Often □ Some of the time

□ Always □ Some of the time

 □ Almost Never

**Social/Emotional Support**

How often do you get the social and emotional support you need: **Sleep**

 □ Always Each night, how many hours of sleep do

 □ Usually you usually get?

 □ Sometimes \_\_\_\_\_\_\_\_\_\_\_ hours

 □ Rarely

 □ Never Do you snore or has anyone told you that

 you snore?

**General Health** □ Yes □ No

In general, would you say your health is

 □ Excellent In the past 7 days, how often have you

 □ Very good felt sleepy during the daytime?

 □ Good □ Always

 □ Fair □ Usually

 □ Poor □ Sometimes

 □ Rarely

How would you describe the condition of your mouth and teeth- □ Never

Including false teeth or dentures?

 □ Excellent

 □ Very good

 □ Good

 □ Fair

 □ Poor

**Instrumental Activities of Daily Living**

In the past 7 days, did you need help from others to take care of things

such as laundry, housekeeping, banking, shopping, using the phone,

food preparation, transportation, or taking your own medications?

 □ Yes □ No

**Activities of Daily Living**

In the past 7 days, did you need help from others to perform everyday

Activities such as eating, getting dressed, bathing, walking, or using the

toilet?

 □ Yes □ No

**Biometric Measures- Self reported**

( to be completed by the patient only when the HRA is not prepopulated using laboratory, electronic medial record (EMR), patient health record (PHR), or other medical practice source data)

**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

**Cholesterol**

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

□ Desirable (below 200)

□ Borderline high (200-239)

□ High (240 or higher)

□ Don’t know/not sure

**Blood Glucose**

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

□ Desirable (below 100)

□ Borderline high (100-125)

□ High (126- Higher)

□ Don’t know/not sure

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)

□ Don’t know/not sure

**Overweight/obesity**

What is your height without shoes? (for example, 5 feet 6 inches= 5’6”)

Feet \_\_\_\_\_\_\_\_\_\_\_ Inches\_\_\_\_\_\_\_\_\_\_\_

What is your weight?

Weight in pounds \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_