Annual Medicare Wellness Visit

Health Risk Assessment

Patient name: _____

Date of birth: _____

Today's date: _____

I. General:

1. In general, how would you rate your overall health?
   - ☐ In good overall health
   - ☐ In fair overall health
   - ☐ In poor overall health

2. Do you have an advanced directive?
   - ☐ Yes
   - ☐ No

II. Physical Activity:

1. In the past 7 days, how many days did you exercise? _____days

2. On the days when you exercised, how long did you exercise? _____minutes per day

3. How intense was your typical exercise?
   - ☐ Exercise-Light (like stretching or slow walking)
   - ☐ Exercise- Moderate (like light weightlifting, brisk walking, jogging, or swimming)
   - ☐ Exercise- Heavy (like heavy weightlifting, running, stair climbing, or faster swimming)
   - ☐ I do not exercise.

III. Alcohol Use:

SDHS Staff: enter points into the response box in the MWV Form

1. How often did you have a drink containing alcohol in the past year?
   - ☐ Never (0 points)
   - ☐ Monthly or less (1 point)
   - ☐ 2-4 times a month (2 points)
   - ☐ 2-3 times a week (3 points)
   - ☐ 4 or more times a week (4 points)

2. How many drinks did you have on a typical day when you were drinking in the past year?
   Note: 1 standard drink = 1.5 ounces of liquor, 12 ounces of beer, or 5 ounces of wine. Please not that a mixed drink may contain more than 1 "standard drink."
   - ☐ None, I do not drink (0 points)
   - ☐ 1 or 2 (0 points)
   - ☐ 3 or 4 (1 point)
   - ☐ 5 or 6 (2 points)
   - ☐ 7 to 9 (3 points)
   - ☐ 10 or more (4 points)

3. How often did you have six or more drinks on one occasion in the past year?
   - ☐ Never (0 points)
   - ☐ Less than monthly (1 point)
   - ☐ Monthly (2 points)
   - ☐ Weekly (3 points)
   - ☐ Daily or almost daily (4 points)

IV. Fall Risk Screening:

1. How many falls have you had in the past year?
   - ☐ No Falls
   - ☐ One fall without injury
   - ☐ At least one fall with an injury (or multiple falls)

V. Nutrition Screening:

1. In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day? (1 serving=1 slice of 100% whole wheat bread, 1 cup of whole grain or high fiber ready to eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or wheat pasta). _____servings a day

2. In the past 7 days, how many servings of fried or high fat food did you typically eat each day? (ex: fried chicken, fried fish, bacon, fries, potato chips, corn chips, creamy salad dressing, whole milk, cream cheese, or mayonnaise) _____servings a day

3. In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving=1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup=size of baseball). _____servings a day

VI. Sleep Hygiene:

1. How many hours do you sleep each night? _____ hours

2. Do you snore or has anyone told you that you snore?
   - ☐ Yes
   - ☐ No

3. In the past 7 days, how often have you felt sleepy during the daytime?
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never

VII. Dental Health

1. How would you describe the condition of your mouth and teeth, including false teeth and dentures?
   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

2. Are you seeing a dentist regularly (within the past year)?
   - ☐ Yes
   - ☐ No

VIII. Biometric Measures: ***Self-Reported*** (to be completed by the patient only when the Health Risk Assessment is not prepopulated using laboratory, electronic medical record (EMR), patient health record (PHR), or other medical practice source data).

1. **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)

2. **Blood Glucose:** If your glucose was checked, what was your fasting food blood glucose (blood sugar) level the last time it was checked?
   - ☐ Desirable (below 100)
   - ☐ Borderline high (100-125)
   - ☐ High (126 or higher)

3. **Cholesterol**: If your cholesterol was checked in the past year, what was your total cholesterol when it was last checked?
   - ☐ Desirable (below 200)
   - ☐ Borderline high (200-239)
   - ☐ High (240 or higher)

IX. Vision and Hearing:

1. Have you had an eye exam within the past year?
   - ☐ Yes. Appointment date: _____
   - ☐ No

2. Do you have difficulty driving, watching TV or doing any of your daily activities because of your eyesight?
   - ☐ Yes
   - ☐ No

3. Do you or your family notice any trouble with your hearing that hasn't been managed with hearing aids?
   - ☐ YES
   - ☐ NO

X. Sexual History:

1. Are you sexually active?
   - ☐ Yes
   - ☐ No
2. Is your sexual partner(s)
   - ☐ Male?
   - ☐ Female?

XI. Safety:

1. Is your housing ***without*** working smoke detectors?
   - ☐ Yes
   - ☐ No
2. Do you always fasten your seatbelt when you are in a car?
   - ☐ Yes
   - ☐ No
3. Do you have guns in the home?
   - ☐ Yes
   - ☐ No
4. If you have guns, are they stored safely? Such as in a locked cabinet or safe.
   - ☐ Yes
   - ☐ No

XII. Social/Emotional Support:

1. Do you have adequate emotional support?
   - ☐ Yes
   - ☐ No

2. Do you live alone?
   - ☐ Yes
   - ☐ No

3. Are you working?
   - ☐ Retired from work
   - ☐ Working part-time
   - ☐ Working full-time
   - ☐ Disabled
   - ☐ Never sought employment

XIII. Activities of Daily Living (circle one)

1.	Do you have difficulty feeding yourself?	YES	NO
2.	Do you have difficulty dressing yourself?	YES	NO
3.	Do you have difficulty using the bathroom by yourself?	YES	NO
4.	Do you have difficulty with mobility (need cane or other device)?	YES	NO
5.	Do you have difficulty bathing yourself?	YES	NO
6.	Do you have difficulty grooming yourself?	YES	NO

XIV. Instrumental Activities of Daily Living (circle one)

1.	Do you have difficulty doing your own shopping?	YES	NO
2.	Do you have difficulty doing your own cooking?	YES	NO
3.	Do you have difficulty doing your own housecleaning?	YES	NO
4.	Do you have difficulty using the telephone yourself?	YES	NO
5.	Do you have difficulty managing your own medications?	YES	NO
6.	Do you have difficulty driving or are unable to drive?	YES	NO
7.	Do you have difficulty using public transport?	YES	NO
8.	Do you have difficulty managing your own finances?	YES	NO

XV. Depression Screening

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

	Not at All	Several Days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking slowly or being fidgety or restless				
Wishing to be dead or of hurting yourself				

If you checked any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

XVI. Anxiety Screening

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

	Not at All	Several Days	More than Half the Days	Nearly Every Day
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid, as if something awful might happen				

If you checked any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult