Medicare Annual Wellness Visit - Health Risk Assessment

General Health

1. How is your overall health
   a. Excellent
   b. Good
   c. Fair
   d. Poor
   e. I don't know

2. How is the health of your mouth and teeth?
   a. Excellent
   b. Good
   c. Fair
   d. Poor
   e. I don't know

3. In the past 6 months, how many times have you been seen in the emergency room?
   a. 0
   b. 1-2
   c. 3-4
   d. 5+
   e. I don't know

4. In the past 6 months, how many times have you been admitted to the hospital
   a. 0
   b. 1-2
   c. 3-4
   d. 5+
   e. I don't know

5. In the past 2 weeks, have you experienced any of the following?
   a. Unexplained weight loss
   b. Change in appetite

6. Do you have problems with vision?
   a. Yes, I use ___contact lenses ___glasses
   b. Yes and I do not use contact lenses or glasses
   c. No

7. Do you have problems with hearing
   a. Yes and I use hearing devices to help me hear
   b. Yes and I do not use hearing devices to help me hear
   c. No

8. Please list any specialty or other care providers that participate in your healthcare

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Provider Name</th>
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<td>Cardiologist</td>
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Activities of Daily Living

1. In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your own medications?
   a. Yes, please explain ________________________________
   b. No

2. In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking or using the toilet?
   a. Yes, please explain ________________________________
   b. No

Functional Ability

1. How long can you walk or move around before needing a break?
   a. 0-5 minutes
   b. 5-15 minutes
   c. 15-30 minutes
   d. 30 minutes to 1 hour
   e. Longer than 1 hour

2. Do you use any of the following devices?
   a. Cane
   b. Walker
   c. Crutches
   d. Wheelchair
   e. I do not use any of these

3. Do you have problems with balance?
   a. Yes
   b. No

4. Have you fallen in the last 6 months?
   a. Yes
   b. No
1. In the past 2 weeks, how often have you felt pain?
   a. Always
   b. Usually
   c. Sometimes
   d. Rarely
   e. Never

2. If you have felt any pain, rate your pain on a scale of 0-10, 0 being no pain and 10 being the worst pain. ______/10

3. If you have felt any pain, where is the pain? ____________________________

4. If you have felt any pain, how do you treat the pain?
   a. Medication
   b. Rest
   c. Heat or Cold
   d. Therapy
   e. Other ________________
   f. No treatment

Physical Activity

1. On average, how many days a week do you exercise? _____ days

   *if you answered is 0, is there an illness or injury preventing you from exercising? ____NO ____Yes Illness/Injury: ____________________________

2. On the days that you exercise, how long do you exercise?
   a. 0-30 minutes
   b. 30 minutes to 1 hour
   c. More than 1 hour
   d. I don’t exercise

3. How intense is your typical exercise?
   a. Light – stretching or slow walking
   b. Moderate - like brisk walking
   c. Heavy – like jogging, swimming
   d. Very heavy – like fast running
   e. I do not exercise

4. What types of exercise do you enjoy? ____________________________

Nutrition

1. How many servings of fruit and vegetables do you usually eat in a day?
   a. None
   b. 1-2
   c. 3-4
   d. 5+
2. How many servings of fiber or whole grain foods do you usually eat in a day?
   a. None
   b. 1-2
   c. 3-4
   d. 5+
   e. I don't know
3. How many servings of meat, fish or other protein do you usually eat in a day?
   a. None
   b. 1-2
   c. 3-4
   d. 5+
   e. I don't know
4. How many servings of fried or high-fat food do you usually eat in a day?
   a. None
   b. 1-2
   c. 3-4
   d. 5+
   e. I don't know

Home and Safety

1. What is your living situation?
   a. Alone
   b. With spouse/family
   c. With a friends or roommate
   d. In a nursing home or assisted living facility
   e. I don't have a place to live
   f. Other
2. Do you feel safe at home?
   a. Yes
   b. No
3. Does your home have working smoke alarms?
   a. Yes
   b. No
4. Do you always fasten your seatbelt when riding in a vehicle?
   a. Yes
   b. No

Social/Emotional Support

1. Which of the following applies to you? (please select all that apply)
   a. I have a supportive family
   b. I have supportive friends
   c. I am involved in church, clubs or other group activities