# Annual Medicare Wellness Health Risk Assessment

Name: _____ Date of Birth: _____ Date of Exam: _____

| 1. PLEASE LIST ANY UPDATES TO YOUR PAST MEDICAL HISTORY | DATE |
|---|---|
| ***For example: Any serious illnesses, surgeries and/or hospital stays*** | |
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| 2. PLEASE LIST ***ALL MEDICATIONS*** INCLUDING ALL OVER THE COUNTER MEDICATIONS | |
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| 3. LIST ALL OTHER PHYSICIANS/PROVIDERS INCLUDING DENTIST AND EYE DOCTOR | | | |
|---|---|---|---|
| **Provider's name** | **Specialty** | **Provider's name** | **Specialty** |
| | | | |
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| 4. LIST WHERE YOU GET YOUR MEDICATIONS AND MEDICAL SUPPLIES | |
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| ***For example: Pharmacies, walker or wheelchair, diabetic supplies, ostomy, oxygen, CPAP*** | |
| **Supplier** | **Problem** |
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| 5. PLEASE CHECK IF YOUR FAMILY HAS HAD ANY OF THE FOLLOWING CONDITIONS: | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ Alcoholism | ☐ Arthritis | ☐ Cancer | ☐ Diabetes | ☐ Obesity | ☐ Heart Disease | ☐ Seizures | ☐ Stroke |
| ☐ Rheumatoid Arthritis | ☐ Kidney Disease | ☐ Liver Disease | ☐ Thyroid Disease | ☐ Other-*Please Indicate:* | | | |

| 6. GENERAL HEALTH, HEARING, AND VISION SCREENING – Please check an answer for each question | |
|---|---|
| In general, how would you say your health is? | ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor |
| In the past 7 days, how much pain have you felt? | ☐ None ☐ Some ☐ A Lot |
| How would you describe the conditions of your mouth and teeth—including false teeth and dentures? | ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor |
| Do you have trouble hearing the television and radio when others do not? | ☐ YES ☐ NO |

| | |
|---|---|
| Do you have to strain or struggle to hear/understand conversations? | ☐YES ☐NO |

| | | |
|---|---|---|
| How many hours of sleep do you usually get? _____Hours | Has anyone told you that you snore? | ☐YES ☐NO |
| How often do you feel sleepy during the day time? | ☐Always ☐Usually ☐Sometimes ☐Rarely ☐Never | |

| 7. ACTIVITIES OF DAILY LIVING -- Please check an answer for each question | |
|---|---|
| Do you live alone? | ☐YES ☐NO |
| Does your home have throw rugs or poor lighting? | ☐YES ☐NO |
| Do you have grab bars in your bathroom? | ☐YES ☐NO |
| Do you have hand rails on the stairs? | ☐YES ☐NO |
| Does your home have functioning smoke alarms? | ☐YES ☐NO |
| Do you need help from others to perform daily activities such as eating, getting dressed, and using the bathroom? | ☐YES ☐NO |
| Do you always fasten your seat belt when you are in a car? | ☐YES ☐NO |

| 8. ADVANCE CARE PLAN | | | |
|---|---|---|---|
| Do you have a plan for End of Life such as: | | | |
| Advance Directive | ☐YES ☐NO | Living Will | ☐YES ☐NO |

| 9. PREVENTIVE SCREENING |
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| When was your last colonoscopy? |

| 10. TOBACCO USE | | | |
|---|---|---|---|
| Have you recently used tobacco? | ☐YES ☐NO | Used a smokeless tobacco product? | ☐YES ☐NO |
| If Yes to either – Would you be interested in quitting within the next month? | | | ☐YES ☐NO |
| Number of packs per day: | | Number of years smoking: | |

| 11. ALCOHOL USE | |
|---|---|
| In the past 7 days, on how many days did you drink alcohol? | |
| How often do you have alcohol during the week? | ☐Never ☐Once ☐2-3 times ☐3 or more times |
| Do you ever drive after drinking, or ride with a driver who has been drinking? | ☐YES ☐NO |

| 12. NUTRITION | |
|---|---|
| How many servings of fruits and vegetables do you typically eat, per day? | How many servings of high fiber or whole grain foods do you typically eat, per day? |
| How many servings of fried or high-fat foods do you typically eat, per day? | How many sugar-sweetened (not diet) beverages do you typically consume, per day? |

| 13. PHYSICAL ACTIVITY | | |
|---|---|---|
| In the past 7 days, how many days did you exercise? | | On days that you exercised, for how long did you exercise (in minutes)? |
| How intense is your typical exercise? | ☐ Not currently exercising ☐ Light (Slow walking) ☐ Moderate (Brisk walking) ☐ Heavy (Jogging/Swimming) ☐ Very Heavy (Stair climbing) | |
| 14. DEPRESSION, ANXIETY, SOCIAL/EMOTIONAL SUPPORT | | |
| How often do you feel down, depressed, or hopeless? | | ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never |
| How often do you feel little interest/pleasure in things? | | ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never |
| How often do you feel nervous or anxious? | | ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never |
| How often are you not able to control/stop your worrying? | | ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never |
| How often is stress a problem for you in handling things such as: Your health, finances, relationships, or work? | | ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never |
| Have your feelings caused you distress or interfered with your ability to get along with family or friends? | | ☐ YES ☐ NO |
| How often do you get the social and emotional support you need? | | ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never |

**PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT.**

**THIS FORM CAN ALSO BE EMAILED TO US AT: MMCFRONTDESK@VAPHYSICIANS.COM**