Health Risk Assessment for Medicare Annual Wellness Visits

Patient's Name:_____ D.O.B:_____/_____/_____

Do you Have a plan for "end of life" issues such as an Advanced Directive or Living Will?

_____Yes _____No

Do you have a Power of Attorney (POA)?

_____Yes _____ Name _____ No

Hearing Loss Screen:

Do you have trouble hearing the television or radio when others do not? _____Yes _____No
Do you have to strain to hear/understand conversations? _____Yes _____ No

Function Screen:

Do you need help with preparing meals, transportation, shopping, taking medications, managing finances or other activities of daily living? _____Yes _____ No
Do you live alone? _____ Yes _____ No
Do you have urinary or fecal incontinence? _____ Yes _____ No

Home Safety Screen:

Does your home have throw rugs, poor lighting, or a slippery tub/shower? _____ Yes _____ No
Does your home have grab bars in bathrooms, handrails on step? _____ Yes _____ No
Does your home have functioning smoke alarms? _____ Yes _____ No
Have you had any falls in the last six (6) months? _____ Yes _____ No
Do you have problems with balance? _____ Yes _____ No

Behavioral Risk Factors:

How many days do you typically exercise in a week? _____
Tobacco user: _____ Current _____ Former _____ Never
In a typical week, how many days do you drink alcohol? _____
Do you always fasten your seat belt when you are in the car? _____ Yes _____ No
Do you protect yourself from the sun when you are outdoors? _____ Yes _____ No

Psychosocial Risk Factors:

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

Feeling down, depressed or hopeless?
_____ Not at all _____ Several days _____ More than ½ the days _____ Nearly every day
Having little interest or pleasure in doing things?
_____ Not at all _____ Several days _____ More than ½ the days _____ Nearly every day

Date: _____