Medicare Annual Health Risk Assessment (HRA)

Demographics

1. What is your Name?_____
2. What is your Date of Birth?_____
3. What is today's date?_____
4. What is your Age?
   a. ☐ 18-64
   b. ☐ 65-69
   c. ☐ 70-79
   d. ☐ 80 or older
5. How new are you to Medicare?
   a. ☐ This is my first year (12 months) of Medicare
   b. ☐ This is my second year of Medicare
   c. ☐ I've been on Medicare for more than 2 years
   d. ☐ I have a Medicare Advantage plan
6. What is your Gender?
   a. ☐ Male
   b. ☐ Female
   c. ☐ Other
7. What is your Race?
   a. ☐ White
   b. ☐ American Indian or Alaskan Native
   c. ☐ Asian
   d. ☐ Black or African American
   e. ☐ Hispanic or Latino
   f. ☐ Native Hawaiian or Other Pacific Islander
   g. ☐ Other
8. What is your Ethnicity?
   a. ☐ Hispanic or Latino
   b. ☐ Not Hispanic or Latino
   c. ☐ Other
9. What is your preferred language?
   a. ☐ English
   b. ☐ Spanish
   c. ☐ Other:_____

General

10. _During the past 4 weeks, how would you rate your **health in general**?
    a. ☐ Excellent
    b. ☐ Very good
    c. ☐ Good
    d. ☐ Fair
    e. ☐ Poor
11. _**How have things been going for you** during the past 4 weeks?
    a. ☐ Very well - could hardly be better
    b. ☐ Pretty good
    c. ☐ Good and bad parts about equal
    d. ☐ Pretty bad
    e. ☐ Very bad - could hardly be worse

Pain

12. _During the past 4 weeks, how much **bodily pain** have you generally had?
    a. ☐ No pain
    b. ☐ Very mild pain
    c. ☐ Mild pain
    d. ☐ Moderate pain
    e. ☐ Severe pain
13. _How often do you use **pain medication**?
    a. ☐ I need pain medication all the time
    b. ☐ Everyday
    c. ☐ Most days or nights
    d. ☐ Sometimes
    e. ☐ Almost Never
    f. ☐ Never
14. _Do you or your family members have any concerns about your memory?
    a. ☐ Yes
    b. ☐ No

Name:_____ Date of Birth:_____

Tobacco/Alcohol/Exercise

15. Do you use **tobacco or vaping**?
    a. ☐ No/never
    b. ☐ Former
    c. ☐ Yes
16. **Do you drink alcohol?**
    a. ☐ No
    b. ☐ Former
    c. ☐ Yes
17. What type of alcohol? (check all that apply)
    a. ☐ Beer
    b. ☐ Liquor (gin, rum, scotch, whiskey, etc.)
    c. ☐ Wine
18. How often do you drink alcohol?
    a. ☐ Daily
    b. ☐ Weekly
    c. ☐ Monthly
    d. ☐ Yearly
    e. ☐ Occasionally
    f. ☐ Rarely
    g. ☐ Socially
19. How many **days of moderate to strenuous exercise**, like a brisk walk, did you do in the last 7 days?
    a. _____ days last week
20. On the days that you engage in moderate to strenuous exercise, like a brisk walk, **how many minutes, on average, do you exercise**?
    a. _____ minutes on average

Social Determinants of Health

21. How hard is it for you to **pay for the very basics** like food, medical care, and heating?
    a. ☐ Very hard
    b. ☐ Hard
    c. ☐ Somewhat hard
    d. ☐ Not very hard
22. Do you feel **stressed** (tense, nervous, anxious, unable to sleep at night) over the **last 4 weeks**?
    a. ☐ Not at all
    b. ☐ Only a little
    c. ☐ To some extent
    d. ☐ Rather much
    e. ☐ Very much
23. Over the last 2 weeks, **how often have been bothered** by having little interest or pleasure in doing things?
    a. ☐ Not at all
    b. ☐ Several days
    c. ☐ More than half the days
    d. ☐ Nearly every day
24. Over the last 2 weeks, **how often have you been bothered** by feeling down, depressed, or hopeless?
    a. ☐ Not at all
    b. ☐ Several days
    c. ☐ More than half the days
    d. ☐ Nearly every day
25. What is your current **marital status**?
    a. ☐ Married
    b. ☐ Widowed
    c. ☐ Divorced
    d. ☐ Separated
    e. ☐ Never married (Single)
    f. ☐ Living with partner
26. In a typical week, how many times do you **talk on the telephone** with family, friends, or neighbors?
    a. _____ times/week
27. In a typical week, how often do you **get together** with friends or relatives?
    a. _____ times/week
28. How often do you attend religious services?
    a. _____ times/week
29. Do you belong to any **clubs or organizations**, such as unions, fraternal, athletic, or school groups?
    a. ☐ Yes
    b. ☐ Yes, but I rarely participate
    c. ☐ No
30. _Do you **feel safe** in your home?
    a. ☐ Yes
    b. ☐ No
    c. ☐ Prefer to discuss in person

Name:_____ Date of Birth:_____

Functional Ability/Safety/Home Environment

31. _Does your home have throw rugs, poor lighting, or a slippery bathtub/shower?
    a. ☐ Yes
    b. ☐ No
32. _Does your home have adequate grab bars in bathrooms, handrails on stairs and steps?
    a. ☐ Yes
    b. ☐ No
33. How many **falls** have you had in the **last year**?
    a. _____ in the last year
34. Did the fall(s) **result in injury**?
    a. ☐ No falls
    b. ☐ No injuries
    c. ☐ Yes, I was injured
35. Do you have **smoke detectors** in your home?
    a. ☐ Yes
    b. ☐ No
36. Do you have **firearms** in your home?
    a. ☐ Yes
    b. ☐ No
37. Do you **always fasten your seat belt** when in a car?
    a. ☐ Yes, usually
    b. ☐ Yes, sometimes
    c. ☐ No
38. Do you have **carbon monoxide detectors** at home?
    a. ☐ Yes
    b. ☐ No
39. _Do you require help with daily activities? (Check all that apply)
    a. ☐ I need help shopping for groceries
    b. ☐ I need help bathing
    c. ☐ I need help getting dressed
    d. ☐ I need help preparing meals
    e. ☐ I have trouble eating or with my teeth
    f. ☐ I need help going to the toilet
    g. ☐ I need help with housework/laundry
    h. ☐ I need help handling money/finances
    i. ☐ I need help keeping track of my medications
    j. ☐ I need help managing my health problems
    k. ☐ I have sexual problems
    l. ☐ I have difficulty driving my car
    m. ☐ I have trouble getting transportation
    n. ☐ I don't need additional help

Functional Limitations

40. How hard is it to **get in and out of cars**?
    a. ☐ No problem
    b. ☐ Difficult
    c. ☐ Unable to
41. How hard is it to go **up or down stairs**?
    a. ☐ No problem
    b. ☐ Difficult
    c. ☐ Unable to
42. How hard is it **to kneel**?
    a. ☐ No problem
    b. ☐ Difficult
    c. ☐ Unable to
43. How hard is it to **put on socks and shoes**?
    a. ☐ No problem
    b. ☐ Difficult, I need help
    c. ☐ Unable to
44. How far can you comfortably **walk without a rest**?
    a. ☐ Not able to
    b. ☐ Short distances
    c. ☐ 1 to 4 blocks
    d. ☐ 5 to 10 blocks
    e. ☐ 10 or more blocks
    f. ☐ I don't know

Hearing

45. Do you have **trouble hearing the television or radio** when others do not?
    a. ☐ Yes
    b. ☐ No
46. Do you have to **strain or struggle to hear/understand** conversations?
    a. ☐ Yes
    b. ☐ No

Medication Reconciliation

47. How often do you have **trouble taking medicines** the way you have been told to take them?
    a. ☐ I do not have to take medicine
    b. ☐ I always take them as prescribed
    c. ☐ Sometimes I take them as prescribed
    d. ☐ I seldom take them as prescribed

Instead of listing every medication you are taking, just bring your *medication bottles* to your appointment.

Name:_____ Date of Birth:_____

Advance Directives

48. Do you have any of these **documents**:
    (please bring a copy to your appointment)
    a. ☐ Healthcare Power of Attorney
    b. ☐ Will
    c. ☐ Living Will

What to bring to your appointment:

1. This packet, filled out
2. If you have a Healthcare Power of Attorney, Will or Living Will
3. Your medication bottles with labels

Prairie Clinic

dedicated to caring for our community
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Care Team (Healthcare Providers):

Provider	**Name & Last Seen**
Cardiologist	
Dermatologist	
Ear, Nose, Throat (ENT)	
Endocrinologist	
Gastroenterologist	
Oncologist	
Optometrist	
Ophthalmologist	
Orthopedist	
Physical Therapy	
Pulmonologist	
Podiatrist	
Psychiatrist/ Psychologist	
Rheumatologist	
Urologist	