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Medicare Annual Wellness Visit
Health Risk Assessment

Patient Name:	DOB:
	today's date:

GENERAL HEALTH

your overall health	☐	excellent	☐	good	☐	fair	☐	poor	☐ don't know
your overall mood from day to day	☐	excellent	☐	good	☐	fair	☐	poor	☐ don't know
any major changes to your health last 12 months?	☐	no	☐	yes:					
How many different prescriptions are you taking?	☐	0-3	☐	4-6	☐	7-10	☐	10+	☐ don't know
How many different supplements are you taking?	☐	0-3	☐	4-6	☐	7-10	☐	10+	☐ don't know
Do you take all of your medications as prescribed?	☐	no meds	☐	yes	☐	sometimes	☐	seldom	☐ no
In the last 12 months have you been to the ER?	☐	0	☐	1-2	☐	3-4	☐	5+	☐ don't know
In the last 12 months have you been admitted?	☐	0	☐	1-2	☐	3-4	☐	5+	☐ don't know
How is the health of your mouth and teeth?	☐	excellent	☐	good	☐	fair	☐	poor	☐ don't know
Do you have a dentist that you see regularly?	☐	yes:	☐	annually	☐	every 6 mo	☐	no	☐ don't know

additional comments:

ADVANCED DIRECTIVES

Do you have any of the following?	☐	advanced care directive	☐	living will	☐	health care power of attorney	
Would you like more information about these?	☐	no	☐	yes			

DIET AND EXERCISE

How would you rate your overall diet?	☐	excellent	☐	good	☐	fair	☐	poor	☐ don't know
number of servings of fruits or vegetables per day? (serving = 1 cup fresh, 1/2 cup cooked)	☐	none	☐	1-2	☐	3-4	☐	5-6	☐ daily
Do you drink sugary beverage?	☐	none/rare	☐	sometimes	☐	daily	☐	multiple daily	
How many days a week do you exercise?	☐	none	☐	1-2	☐	3-4	☐	5+	
On these days, how long did you exercise?	☐	0-30 min	☐	30-60 min	☐	over an hour			
How intense is your exercise?	☐	light (stretch, walk)	☐	moderate (brisk walk)	☐	heavy (jog, swim)	☐	very heavy (fast run)	

additional comments:

SUBSTANCE USE

Do you use any tobacco products?	☐	never	☐	quit:	☐	yes	Type:
Are you interested in quitting tobacco?	☐	no	☐	maybe	☐	yes	
Do you drink alcoholic drinks? How much? What?	☐	none	☐	yes	# per WEEK?		what?
Do you drink caffeinated drinks? How much? What?	☐	none	☐	yes	# per DAY?		what?
Do you use any recreational substances?	☐	no	☐	yes	Type:		

additional comments:

HOME/SAFETY

What is your living situation? ☐ w/ spouse ☐ w/ pets ☐ w/ friend / roomate ☐ w/ child(ren) ☐ alone ☐ in assited living

Is your home: ☐ single level ☐ multi level

Do you fasten your seatbelt when in a vehicle? ☐ always ☐ sometimes ☐ no

Does your home have any throw or area rugs? ☐ yes ☐ no

Does your home have grab bars in the bathroom? ☐ yes ☐ no

additional comments:

SLEEP

How many hours of sleep do you usually get? ☐ 0-4 ☐ 5-7 ☐ 8-9 ☐ 10+

How often do you nap? ☐ never ☐ rarely ☐ sometimes ☐ often ☐ daily

Do you snore or has anyone told you that you snore? ☐ no ☐ yes ☐ don't know

In the past 4 weeks, how often have you felt sleepy during the day? ☐ never ☐ rarely ☐ sometimes ☐ often ☐ always

Do you get up in the night to use the restroom? ☐ no ☐ yes How many times?

PAIN ASSESSMENT

In the past 4 weeks, how much body pain have you generally had? ☐ no pain ☐ rarely ☐ sometimes ☐ often ☐ always

Is this pain chronic (old) or acute (new)? ☐ chronic ☐ acute

Where is the pain?

How do you treat the pain? ☐ rest ☐ heat/cold ☐ therapy ☐ other: ☐ OTC meds ☐ prescription meds

additional comments:

SOCIAL/EMOTIONAL

Do you get social / emotional support you need? ☐ always ☐ usually ☐ sometimes ☐ rarely ☐ never

Which of the following applies to you? ☐ supportive family ☐ participate in church, clubs, group activities ☐ supportive friends ☐ none

Do you get out and meet w/ family and friends? ☐ always ☐ usually ☐ sometimes ☐ rarely ☐ never

In the past 4 weeks, how much have you been bothered by feeling anxious, depressed, irritiable, sad or downhearted? ☐ not at all ☐ slightly ☐ moderately ☐ quite a bit ☐ extremely

In the past 4 weeks, has your physical and emotional health limited your social activties w/ family, friends, neighbors or groups? ☐ not at all ☐ slightly ☐ moderately ☐ quite a bit ☐ extremely

During the past 12 months, have you experienced confusion or memory loss that is happening more often or is getting worse? ☐ no ☐ yes additional comments:

During the past 12 months, has anyone told you that your forgetfullness is happening more often or is getting worse? ☐ no ☐ yes additional comments:

PHQ-2

In the past 2 weeks how often have you been bothered by:

having little interest or pleasure in doing things?	☐ not at all	☐ several day	☐ more than half the days	☐ nearly every day
feeling down, depressed or hopeless?	☐ not at all	☐ several day	☐ more than half the days	☐ nearly every day

any explanation:

FUNCTIONAL STATUS

Instrumental ADLs

In the past 4 weeks, which have you needed assistance with?

☐ NONE
☐ shop for groceries
☐ use the telephone
☐ housework
☐ handle finances
☐ ALL
☐ drive or use public transportation
☐ make meals
☐ take medications

any explanation:

ADLs

In the past 4 weeks, which have you needed assistance with?

☐ NONE
☐ bathing ☐ dressing
☐ using the restroom
☐ ALL
☐ eating ☐ walking
☐ transferring in/out of chairs, etc

any explanation:

Ambulation

Any trouble walking for extended periods?	☐ no	☐ sometimes	☐ yes		
Do you use any of these assistive devices?	☐ NONE	☐ cane	☐ walker	☐ wheelchair	☐ other:
Do you have trouble with your balance?	☐ no	☐ sometimes	☐ yes		
Have you fallen in the past year?	☐ no	☐ yes			
if so, what happened?					

any explanation:

Sensory ability

Do you have problems with vision?	☐ no	☐ sometimes	☐ yes
Do you have eyeglasses or contacts?	☐ no	☐ sometimes	☐ yes
Do you have problems with hearing?	☐ no	☐ sometimes	☐ yes
Do you use hearing aids or other devices?	☐ no	☐ sometimes	☐ yes
-Are you interested in a referral to hearing specialist?	☐ no	☐ yes	☐ not sure

any additional comments:

revised: 09/29/23da