Medicare Annual Wellness Visit
Health Risk Assessment

NAME: _____ **DOB:** _____

A. Social History

Do you smoke?..... ❑ No ❑ Yes If *Yes*, packs/day? _____

Do you drink alcohol?..... ❑ No ❑ Yes If *Yes*, drinks/week? _____

Do you use illicit drugs?..... ❑ No ❑ Yes If *Yes*, type? _____

Are you sexually active?.... ❑ No ❑ Yes

B. Depression Screening

1. In the past 2 weeks, how often have you felt little interest or pleasure in doing things?
   ❑ Not at all ❑ Several days ❑ More than half of the days ❑ Nearly every day
2. In the past 2 weeks, how often have you felt down, depressed or hopeless?
   ❑ Not at all ❑ Several days ❑ More than half of the days ❑ Nearly every day

C. Medical/Surgical History

3. Do you have any **new medical problems** diagnosed since your last annual visit? ..... ❑ No ❑ Yes
   If *YES*, list here..... _____
4. Have you had any **surgical procedures** since your last annual visit? ..... ❑ No ❑ Yes
   If *YES*, list here..... _____

D. Health Assessment

5. In general, how would you say that your health is:
   ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor
6. In the **past seven days**, have you experienced any of the following?
   ❑ None ❑ New or increased pain ❑ New or increased fatigue ❑ Loneliness
   ❑ Social Isolation ❑ Stress ❑ Anger

E. Advanced Care Planning

7. Do you have a Durable Power of Attorney? ..... ❑ No ❑ Yes
8. Do you have a Living Will ..... ❑ No ❑ Yes
9. Do you have other Advanced Care Planning documents? ..... ❑ No ❑ Yes

(Please turn form over to complete)

Medicare Health Risk Assessment (cont.)

F. Health Habits

10. Do you **exercise** for at least 20 minutes 2-3 times per week? ..... ❑ No ❑ Yes

11. Have you **lost any weight *without trying*** in the past 3 months? ..... ❑ No ❑ Yes

12. Do you **eat *fewer than* 2 meals** per day? ..... ❑ No ❑ Yes

13. Has it been over 1 year since you last saw the **dentist**? ..... ❑ No ❑ Yes

14. Do you or your family notice any trouble with your **hearing**? ..... ❑ No ❑ Yes

If *YES* do you have hearing aids? _____

15. Do you have difficulty driving, watching TV, reading, or doing any of your daily activities because of your **eyesight**? ..... ❑ No ❑ Yes

If *YES* do you wear corrective lenses? _____

G. Safety

16. Does your home have **unfastened rugs** or **poor lighting**? ..... ❑ No ❑ Yes

17. Do you ever ride in the car *without* fastening your **seatbelt**? ..... ❑ No ❑ Yes

H. Activities of Daily Living

18. In the past 7 days, did you need help to perform any of the following everyday activities?

❑ None ❑ Eating ❑ Dressing ❑ Grooming
❑ Bathing ❑ Toileting ❑ Walking/Balance

19. In the past 7 days, did you need help from others to take care of any of the following?

❑ None ❑ Laundry ❑ Housekeeping ❑ Banking/Finance ❑ Shopping
❑ Telephone Use ❑ Food Prep ❑ Transportation ❑ Taking Medication

If *YES* to any of the above, do you have a caregiver, home health, reside in an assisted living or nursing facility? _____

I. Falls Risk Screening

20. Have you **fallen 2 or more times** in the past year? ..... ❑ No ❑ Yes

21. Have you had any **fall with injury** in the past year? ..... ❑ No ❑ Yes

J. Immunizations

22. Have you received any immunizations outside of our health system since your last annual visit? ..... ❑ No ❑ Yes

If *YES* list vaccine and date given: _____

360 Exam Patient Questionnaire

Patient Name: _____ Date: _____

Please circle all appropriate answers 

In the last 2 weeks have you had little interest or pleasure in doing things? Yes / No

In the last 2 weeks have you felt down, depressed, or hopeless? Yes / No

Circle items that pertain to you: Fell in last 3 months/Incontinence/problem walking/confusion

On a scale of 0-10 (0=no pain and 10= severe pain) how would you rate your pain level?_____

Have you used more than 15 days of narcotic pain medication in the past year? Yes / No

In the past 3 months have you leaked urine? Yes / No

Smoking Status: Never smoked / Current smoker / Previous smoker—Year stopped _____

Did you have a drink containing alcohol in the past year? Yes / No

How often did you drink? Daily / ___X/week / ___X/month / less than 1/month

How many drinks on the days you drank: 1-2 / 3-4 / 5-6 / 7-9 / 10 or more

Do you use recreational or street drugs? Yes / No

Marital Status: Married / Single / Divorced / Separated / Widowed

Current physical activity compared to last year: Same / More / Less

Ambulatory Status: Independent / uses cane / uses walker / uses wheelchair or scooter

Problems with balance, walking, or falling? Yes / No

Is your hearing normal? Yes / No

Is your speech normal? Yes / No

Is your vision normal? Yes / No - wears glasses or contacts

Living Condition: Lives alone / With spouse / With Family / Assisted Living or Nursing Home

Memory compared to last year? Same / Better / Worse

Are you able to bathe yourself? Yes / No

Are you able to dress yourself? Yes / No

Are you able to use the toilet without help? Yes / No

Do you have full control over urination and bowel movements without accidents? Yes / No

Are you able to eat without help? Yes / No

Are you able to prepare your meals without help? Yes / No

Do you have a living will? Yes / No Would you like information about a living will? Yes / No