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Medicare Annual Wellness Visit – Health Risk Assessment

Please Print Your Name and Date of Birth Name: DOB:

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| --- | --- | --- | --- | --- | --- |
| General Health | | | | | |
| How is your overall health? | | □ Excellent □ Good □ Fair □ Poor □ I don’t know | | | |
| How many different prescriptions are you taking? | | □ 0-3 □ 4-6 □ 7-10 □ 10+ □ I don’t know | | | |
| Do you take all your medications as prescribed? | | □ Yes □ Sometimes □ Almost Never  □ No □ I don’t take medication | | | |
| How many times in the last 6 months have you been to the Emergency Room? | | □ 0 □ 1-2 □ 3-4 □ 5+ □ I don’t know | | | |
| How many times in the last 6 months were you admitted to the hospital? | | □ 0 □ 1-2 □ 3-4 □ 5+ □ I don’t know | | | |
| Tobacco and Alcohol Use | | | | | |
| Do you use any tobacco products? | | □ Yes □ No What form? | | | |
| Are you interested in quitting tobacco? | | □ Yes □ No □ I don’t use tobacco | | | |
| How many times in the past year have you had four or more alcoholic drinks in a day? | | □ None □ 1-2 □ 3-4 □ 5+ | | | |
| Are you interested in receiving help for any other types of substance abuse? | | □ Yes □ No □ I don’t use other substance | | | |
| Nutrition | | | | | |
| How many servings of fruits and vegetables do you usually eat each day? | | □ None □ 1-2 □ 3-4 □ 5+ □ I don’t know | | | |
| How many servings of fiber or whole grain foods do you usually eat each day? | | □ None □ 1-2 □ 3-4 □ 5+ □ I don’t know | | | |
| How many servings of meat, fish, or other protein do you usually eat each day? | | □ None □ 1-2 □ 3-4 □ 5+ □ I don’t know | | | |
| How many servings of fried or high-fat foods do you usually eat each day? | | □ None □ 1-2 □ 3-4 □ 5+ □ I don’t know | | | |
| How many servings of sugar-sweetened drinks do you usually have each day? | | □ None □ 1-2 □ 3-4 □ 5+ □ I don’t know | | | |
| Physical Activity | | | | | |
| How many days a week do you exercise? | | □ None □ 1-2 □ 3-4 □ 5+ □ I don’t know | | | |
| On the days you exercised, how long did you exercise? | | □ 0-30 min □ 30 min – 1 hour □ More than 1 hour  □ I don’t know □ I don’t exercise | | | |
| How intense is your exercise? | | □ Light (stretching/slow walking) □ Moderate (brisk walking)  □ Heavy (jogging/swimming) □ Very heavy (running fast)  □ I don’t know □ I don’t exercise | | | |
| Sleep | | | | | |
| How many hours of sleep do you usually get? | | □ 0-3 □ 4-6 □ 7-10 □ 10+ □ I don’t know | | | |
| Do you snore or has anyone told you that you snore? | | □ Yes □ No □ I don’t know | | | |
| In the past 7 days, how often have you felt sleepy during the daytime? | | □ Often □ Sometimes □ Almost Never □ Never □ I don’t know | | | |
| Functional Status | | | | | |
| Instrumental Activities of Daily Living | | | | | |
| Which of the following can you do without help? | | □ Shopping  □ Laundry  □ Housework  □ Handle Finances | | | □ Drive  □ Make meals  □ Take medications  □ None of these |
| Activities of Daily Living | | | | | |
| Which of the following can you do on your own without help? | | □ Bathe □ Dress □ Eat □ Walk □ Transfer (in/ out of chairs)  □ Use the restroom □ None of these | | | |
| Ambulation Status | | | | | |
| How long can you work or move around? | | □ 0-5 min □ 5-15 min □ 15-30 min □ More than 1 hour  □ I don’t know | | | |
| Which of these assistive devices do you use? | | □ Cane □ Walker □Wheelchair □Crutches □Other □None | | | |
| Do you have trouble with your balance? | | □Yes □ No | | | |
| Have you fallen in the last 12 months? | | □Yes □No | | | |
| Sensory Ability | | | | | |
| Do you have problems with vision? | | □ Yes □ No □ I don’t know | | | |
| Do you use eyeglasses or contact lenses? | | □ Yes □ No □ I don’t know | | | |
| Do you have problems with hearing? | | □ Yes □ No □ I don’t know | | | |
| Do you use hearing aids or other devices to help you hear? | | □ Yes □ No □ I don’t know | | | |
| Pain | | | | | |
| In the last two weeks, how often have you felt pain?  □ Almost all of the time  □ Most times  □ Sometimes  □ Almost never  □ No pain | Where is the pain? □ No Pain    Or  Mark all areas on the image | | | How do you treat the pain?  □ Medication  □ Rest  □ Heat or Cold  □ Therapy  □ Other ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­  □ No treatment  □ No pain | |
| Rate your pain on a scale of 0-10 with 0 being no pain and 10 being the worst pain | | | | | |
| Home/ Safety | | | | | |
| What is your living situation? | | □ Alone □ With my spouse or other family  □ With a friend or roommate  □ In a nursing home or assisted living facility  □ I don’t have a place to live □ Other | | | |
| Do you fasten your seatbelt in vehicles? | | □ Yes □ No | | | |
| Depression | | | | | |
| In the last two weeks, how often have you been bothered by any of the following problems? | | | | | |
| 1. Little interest or pleasure in doing things. | | □ Not at all □ Several Days □More than half the days  □ Nearly every day | | | |
| 1. Feeling down, depressed, or hopeless. | | □ Not at all □ Several Days □More than half the days  □ Nearly every day | | | |
| Social/ Emotional Support | | | | | |
| Which of the following applies to you? | | □ I have a supportive family □ I have supportive friends  □ I participate in church, clubs, or other group activities □None | | | |
| How often do you get out and meet with family and friends? | | □ Often □ Sometimes □ Almost Never □ None | | | |
| Advance Directives | | | | | |
| Do you have a healthcare power of attorney or living will? | | | □ Yes □ No □ I don’t know | | |
| Would you like more information? | | | □ Yes □ No | | |
|  | | | | | |
| In this space, please indicate anything you would like us to know. | | | | | |
|  | | | | | |

In the circle below:

1. Draw all of the numbers as they would appear on the face of a clock

2. Draw the hands of the clock to the time of 2:50