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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 PainOrMark 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