Medicare Annual Wellness Visit Patient Health Risk Assessment

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_/\_\_/\_\_ Today’s Date: \_\_/\_\_/\_\_

Appt Date: \_\_/\_\_/\_\_ Appt Time\_\_:\_\_\_am/pm

Form Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We strive to provide you the best and most comprehensive care; care that helps you be well, stay well and realize your goals. To achieve this, it is important to update your provider with the most current health information.

During your upcoming visit, your provider will perform a health risk assessment (HRA) and develop or update personalized prevention Plan (PPP).

Please begin with these two questions so that we can understand what personal goals you hope to achieve in the year ahead.

**Your Health and Wellness Goals**

What do you wish to achieve in the coming year?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What is preventing you from achieving your goal?

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Do you have a living will or healthcare power of attorney?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to discuss advance care planning and goals of care with your provider at this visit?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In preparation for your visit, please provide your current:

1. Medication List. Please bring your current bottles or updated list of medications, including over the counter, prescriptions, vitamins/supplements to your appointment

**Care Coordination Team**

Please list all the providers who are involved in your care in the table below.

|  |  |  |
| --- | --- | --- |
| **Type of Provider** | **Provider Name** | **Phone Number** |
| Cardiologist |  |  |
| Endocrinologist |  |  |
| Gastroenterologist |  |  |
| Hematologist |  |  |
| Neurologist |  |  |
| Oncologist |  |  |
| Ophthalmologist |  |  |
| Psychiatrist |  |  |
| Pulmonologist |  |  |
| Urologist |  |  |
| Home Health Care |  |  |
| Durable Medical Equipment Supplier |  |  |
| Other Specialist  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Last Eye Exam Date: \_\_\_**

**Hearing Aid \_\_Yes\_\_ No**

**Hearing Screening**

Please indicate with a check mark if you experience any of the following.

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Do you have a problem hearing the telephone? |  |  |
| Do you have trouble hearing the television or radio? |  |  |
| Do people complain that you turn the TV volume up too high? |  |  |
| Do you have a strain to understand conversation? |  |  |
| Do you find yourself asking to repeat themselves? |  |  |
| Do many people you talk to seem to mumble (or not speak Clearly)? |  |  |

**Fall Screening**

Please indicate with a check mark if you experience any of the following.

|  |  |  |
| --- | --- | --- |
| Fallen in the past year? | Yes\_\_ | No\_\_ |
| Number of falls in the past year | \_\_\_ |  |
| Any injuries from falls? | Yes\_\_ | No\_\_ |
| Feels unsteady when standing or walking | Yes\_\_ | No\_\_ |
| Worries about falling? | Yes\_\_ | No\_\_ |

**Activity of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)**

Please select the response which best describes your abilities.

|  |  |  |  |
| --- | --- | --- | --- |
| Do you need help from others for your personal care such as eating, dressing, toileting, or getting around the house? | Yes\_\_ | No\_\_ |  |
| Do you experience incontinence? | Yes\_\_ | No\_\_ |  |
| Do you need help with using the telephone? | Yes\_\_ | No\_\_ |  |
| Do you need help with shopping? | Yes\_\_ | No\_\_ |  |
| Do you need help with food preparation? | Yes\_\_ | No\_\_ |  |
| Do you need help with housekeeping? | Yes\_\_ | No\_\_ |  |
| Do you need help with laundry? | Yes\_\_ | No\_\_ |  |
| Do you need help handling finances? | Yes\_\_ | No\_\_ |  |
| Do you drive? | Yes\_\_ | No\_\_ |  |
| Do you manage your own medication? | Yes, independent\_\_ | Yes, independent with pre pour\_\_ | No\_\_ |

**Health and Safety Screening**

Please check the responses which best describe your status**.**

Health Status

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| In general, do you report your health as | Excellent\_\_ | Good\_\_ | Fair\_\_ | Poor\_\_ |
| In general, do you report your life as | Excellent\_\_ | Good\_\_ | Fair\_\_ | Poor\_\_ |
| Do you report sleep patterns as | Sleeping well\_\_ | Up all night\_\_ | Restless\_\_ | Sleeping more\_\_ |
| Have you seen a dentist in the last year | Yes\_\_ | No\_\_ |  |  |

Physical Activity

Do you exercise for about 20 minutes or more three days a week? No\_\_ Yes, sometimes\_\_ Yes most of the time\_\_ Yes always\_\_

Nutritional Assessment

Do you eat a balanced diet including daily serving of fruits, vegetables, and whole grains? No\_\_ Yes, sometimes\_\_ Yes most of the time\_\_ Yes, always\_\_

Safety

|  |  |  |
| --- | --- | --- |
| Do you live alone? | Yes\_\_ | No\_\_ |
| Does your home have throw rugs, poor lighting or a slippery bathtub shower? | Yes\_\_ | No\_\_ |
| Does your home have functioning smoke detection? | Yes\_\_ | No\_\_ |
| Do you use any assistive devices? | Yes\_\_ | No\_\_ |
| Do you always Fasten your seatbelt? | Yes\_\_ | No\_\_ |

**Depression Screening (PHQ-2)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the last 2 weeks, how often have you been bothered by any of the following?  *Please circle one response for each question*. | Not at all | Several days | More than half the days | Nearly every day |
| 1. Do you have little interest or pleasure in doing things? | **0** | **1** | **2** | **3** |
| 1. Do you feel down, depressed, or hopeless? | **0** | **1** | **2** | **3** |

**Medical History**

Please indicate with a check mark if you experience any of the following.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |
| ADD/ADHD |  |  | HIV/AIDS |  |  |
| Allergic Rhinitis |  |  | Hypercholesterolemia |  |  |
| Allergies |  |  | Hypertension |  |  |
| Anemia |  |  | Inflammatory bowel disease |  |  |
| Anxiety |  |  | Jaundice |  |  |
| Arthritis |  |  | Kidney disease |  |  |
| Asthma |  |  | Meningitis |  |  |
| Cancer |  |  | Myocardial infarction |  |  |
| Cataracts |  |  | Nerve/ muscle disease |  |  |
| CHF |  |  | Obesity |  |  |
| Clotting disorder |  |  | Osteoporosis |  |  |
| COPD |  |  | Pneumonia |  |  |
| Depression |  |  | Scoliosis |  |  |
| Diabetes mellitus |  |  | Seizures |  |  |
| Eating Disorder |  |  | Sickle cell anemia |  |  |
| Eczema |  |  | Stroke |  |  |
| Emphysema |  |  | Substance abuse |  |  |
| GERD |  |  | Thyroid disease |  |  |
| Glaucoma |  |  | Tuberculosis |  |  |
| Headache |  |  | Ulcers (GI) |  |  |
| Hearing loss |  |  | UTI |  |  |
| Heart murmur |  |  | Varicella |  |  |
| Hepatitis |  |  | Vision Problems |  |  |

Any other condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History**

Please indicate with a check mark if you experienced any of the following.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |
| Adenoidectomy |  |  | Hernia repair |  |  |
| Appendectomy |  |  | Joint replacement |  |  |
| Brain surgery |  |  | Lymph node biopsy |  |  |
| CABG |  |  | Mastectomy |  |  |
| Cholecystectomy |  |  | Prostate surgery |  |  |
| Colon surgery |  |  | Small intestine surgery |  |  |
| Cosmetic surgery |  |  | Spine surgery |  |  |
| Eye surgery |  |  | Umbilical hernia |  |  |
| Fracture surgery |  |  | Valve replacement |  |  |
| Gastronomy |  |  | Vasectomy |  |  |
| Heart Surgery |  |  | VP shunt |  |  |

Any other surgery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Please fill in any family history of health problems that you are aware of.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Relationship | Name | Status | Problems | Age of onset | Comments |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Preventative Screenings**

Please indicate if you received any of the following screenings and the date of screening and findings.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Screening** | **Yes** | **No** | **Date of Service** | **Findings** |
| Colon cancer screening |  |  |  |  |
| Mammogram (for women) |  |  |  |  |
| Bone Density (for women) |  |  |  |  |
| Abdominal Aortic Aneurysm Ultrasound/Scan (for some men) |  |  |  |  |
| Dilated eye exam (for patients with diabetes) |  |  |  |  |
| Pap Smear |  |  |  |  |

**Immunizations: Date of Administration**

Please indicate if you have received any of the following immunizations and list date of last immunization.

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunization** | **Yes** | **No** | **Date of Administration** |
| COVID-19 Vaccine | \_\_Pfizer \_\_Moderna \_\_J&J |  |  |
| Influenza |  |  |  |
| Pneumococcal (PPSC-23, Pneumovax) |  |  |  |
| Pneumococcal (PCV-13, Prevnar) |  |  |  |
| Tdap |  |  |  |
| Zostavax |  |  |  |
| Shingrix |  |  |  |

**Tobacco History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Tobacco** | | **E-Cigarette/Vaping** | |
| Tobacco use | \_\_Yes \_\_No  \_\_Every Day  \_\_Some Days  \_\_Former  \_\_Never  \_\_Passive Smoke Exposure | E- Cigarette/Vaping Use | \_\_ Every Day  \_\_ Some Days \_\_Former  \_\_Never User  \_\_User – Current |
| Start Date |  | Start Date |  |
| Quit Date |  | Quit Date |  |
| Types | \_\_Cigarettes \_\_Pipe \_\_Cigars | Passive Exposure |  |
| Packs/Day |  | Cartridges/Day |  |
| Years |  | Comments |  |
| Ready to Quit | \_\_Yes \_\_No |  |  |
| Smokeless Tobacco Use | \_\_Current User  \_\_Former User  \_\_Never Used |  |  |
| Types | \_\_Snuff \_\_Chew |  |  |
| Smokeless Tobacco Quit Date |  |  |  |
| Comments |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **E-Cigarette/Vaping Substances** | **Yes** | **No** | **E-Cigarette/Vaping Devices** | **Yes** | **N0** |
| Nicotine |  |  | Disposable |  |  |
| THC |  |  | Pre-filled or Refillable Cartridge |  |  |
| CBD |  |  | Refillable Tank |  |  |
| Flavoring |  |  | Pre-filled Pod |  |  |
| Other\_\_\_\_\_\_\_\_\_\_\_ |  |  | Other\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Social History**

Alcohol

* **Alcohol Use:** \_\_Yes \_\_Not Currently \_\_Never \_\_Defer
* **# of Drinks/Week:** \_\_Glasses of wine \_\_Cans of beer \_\_Shots of liquor \_\_Standard drinks or equivalent
* **Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance

* **Drug/Substance Use:** \_\_Yes \_\_Not Currently \_\_Never \_\_Defer
* **Types:** \_\_Amphetamines \_\_Amyl nitrate \_\_Anabolic steroids \_\_Barbiturates \_\_Benzodiazepines \_\_“Crack” cocaine \_\_Cocaine \_\_Codeine \_\_Fentanyl \_\_Flunitrazepam \_\_GHB \_\_Hashish \_\_Heroin \_\_Hydrocodone \_\_Hydromorphone \_\_Ketamine \_\_LSD \_\_Marijuana/Cannabis \_\_MDMA (ecstasy) \_\_Mescaline \_\_Methamphetamines \_\_Methaqualone \_\_Methylphenidate \_\_Morphine \_\_Nitrous oxide \_\_Opium \_\_Oxycodone \_\_PCP \_\_Psilocybin \_\_Solvent inhalants \_\_Other
* **Use/Week: \_\_**
* **Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider’s Signature Date Reviewed with Patient**