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Medicare Health Risk Assessment

Date:
Name:

Demographics/Living Arrangements

1. Is there anyone else involved with your health care decisions?
   ☐ Self ☐ Family ☐ Power of Attorney ☐ Public Fiduciary
   ☐ Guardian ☐ Spouse/Partner ☐ Other
   If yes, Name: Phone:

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2. Do you have any special language and/or cultural needs?
   ☐ Yes ☐ No
   If yes, what are they?

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3. What is your current living arrangement? (Mark all the apply)
   ☐ Alone ☐ With spouse/partner ☐ Family member/friend
   ☐ Paid Caregiver ☐ Independent Living Facility/ Senior Housing or apartment
   ☐ Congregate or Assisted Living ☐ Nursing Home Facility

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4. Are you a caregiver for someone else?
   ☐ Yes ☐ No
   If yes, who?

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5. Do you have a caregiver who provides you with any assistance?
   ☐ Yes ☐ No
   If yes, what type of assistance?

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6. Physical Characteristics:
   Hearing: ☐ Good ☐ Fair ☐ Poor ☐ Good with Hearing Aid
   Vision: ☐ Good ☐ Fair ☐ Poor ☐ Good with Glasses

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7. Are you currently receiving any of the following services from an agency? (Check all that apply)
   ☐ Visiting Nurse ☐ Social Worker ☐ Physical Therapy
   ☐ Occupational Therapy ☐ Speech Therapy ☐ Home Health Aid
   ☐ Adult Day Care Center ☐ Transportation Service ☐ Home Delivery Meds
   ☐ Homemaker/Chore Service ☐ N/A

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8. Do you use any of the following special equipment?

☐ Hospital Bed	☐ Hoyer Lift	☐ Grab bars
☐ Bedside Commode	☐ Wheelchair	☐ Cane
☐ Walker	☐ Other	☐ No special equipment

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9. Do you receive any of the following special treatments?

☐ Tube feeding	☐ Tracheostomy Care	☐ Ostomy Care
☐ Wound Care	☐ Chemotherapy	☐ Oxygen
☐ CPAP	☐ Insulin Pump	☐ Nebulizer
☐ Dialysis	☐ No special treatments	

Advance Care Planning

10. Have you completed a Living Will, Advance Directives, or other Health Care Wishes document?

☐ Yes ☐ No ☐ I don't know

If yes, please bring a copy with you to your next appointment with our office.

Health & Well Being

11. In general, how do you rate your health overall?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

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12. How many medications (prescription and over-the-counter) do you take on a regular basis?

☐ None ☐ 1-4 ☐ 5-9 ☐ 10+

Please bring a list of prescription and over-the-counter medications with you on your next appointment with our office.

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13. Without wanting to, have you lost 10 pounds or more in the past 2 months?

☐ Yes ☐ No

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14. In the past 6 months, how may times have you....

	None	1	2	3	4-5	6+
Visited a doctor's office or clinic?	☐	☐	☐	☐	☐	☐
Gone to an emergency room or Urgent Care Center?	☐	☐	☐	☐	☐	☐
Stayed overnight as a patient in a hospital?	☐	☐	☐	☐	☐	☐

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15. Do you currently see 3 or more doctors on a regular basis?
☐ Yes ☐ No
Please bring in a list of doctor's you see regularly with you to your next appointment with our office.

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16. Alcohol Use:
☐ Yes ☐ No
How many drinks per day? How many drinks per week?

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17. How often do you use prescription medication other than exactly as prescribed to you?
☐ Never ☐ Sometimes ☐ Often
How often do you use recreational or illegal drugs?
☐ Never ☐ Sometimes ☐ Often

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18. In the last 30 days have you used tobacco?
Smoked ☐ Yes ☐ No
Smokeless ☐ Yes ☐ No
If you've smoked or used smokeless tobacco recently, would you be interested in quitting tobacco within the next month?
☐ Yes ☐ No

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19. How often do you feel sad or depressed?
☐ Never ☐ Sometimes ☐ Often ☐ Always
How often do you feel anxious or nervous?
☐ Never ☐ Sometime ☐ Often ☐ Always

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20. Do you have a history of emotional or psychiatric problems or have you ever seen a mental health professional?
☐ Yes ☐ No

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21. In the past 7 days, how many days did you exercise, such as a brisk walk, for at least 20 minutes per day?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ ☐ I did not exercise

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22. Do you, like many people, have problems with bladder control or getting to the bathroom on time?
☐ Yes ☐ No

23. In the past 7 days, how much did pain interfere in your day-to-day activities?
☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

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24. In the past year, have you had any of the following screening tests or vaccines?

		I've done this in the past year **Date**			**Please help me schedule an appointment**		
Breast Cancer Screening	☐ Yes		☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A
Colorectal cancer screening	☐ Yes		☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A
Cervical Cancer screening (PAP)	☐ Yes		☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A
Bone Mineral Density Screening	☐ Yes		☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A
Flu vaccine	☐ Yes		☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A
Pneumonia vaccine	☐ Yes		☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A
Shingles vaccine	☐ Yes		☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A
Eye exam	☐ Yes		☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A
Dental exam	☐ Yes		☐ No	☐ N/A	☐ Yes	☐ No	☐ N/A

Activities/Safety

25. In the past year, have you fallen to the ground or floor?
☐ None ☐ 1-2 Times ☐ 4 times or more

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26. Do you have any concerns about safety in your home?
☐ Yes ☐ No

27. How much difficulty do you have doing the following activities?

Bathing:
☐ No Difficulty ☐ Some Difficulty ☐ Cannot do at all

Using the toilet:
☐ No Difficulty ☐ Some Difficulty ☐ Cannot do at all

Dressing:
☐ No Difficulty ☐ Some Difficulty ☐ Cannot do at all

Eating:
☐ No Difficulty ☐ Some Difficulty ☐ Cannot do at all

Getting in /out of bed or chairs:
☐ No Difficulty ☐ Some Difficulty ☐ Cannot do at all

Walking:
☐ No Difficulty ☐ Some Difficulty ☐ Cannot do at all

If you have difficulty with any items above, does someone help you with any of these tasks?
☐ Yes ☐ No

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28. How much difficulty do you have doing the following activities?

Taking medications:
☐ No Difficulty ☐ Some Difficulty ☐ Cannot do at all

Managing money:
☐ No Difficulty ☐ Some Difficulty ☐ Cannot do at all

Preparing Meals:
☐ No Difficulty ☐ Some Difficulty ☐ Cannot do at all

Shopping for groceries:
☐ No Difficulty ☐ Some Difficulty ☐ Cannot do at all

Doing routine household chores:
☐ No Difficulty ☐ Some Difficulty ☐ Cannot do at all

If you have difficulty with any of the items listed above, does someone help you with any of these tasks?
☐ Yes ☐ No