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Medicare Annual Wellness Visit
HEALTH RISK ASSESSMENT

Patient Name: _____ **Date of Birth:** _____

GENERAL HEALTH					
1. How is your overall health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ I don't know
2. How many different prescriptions are you taking?	☐ 0-3	☐ 4-6	☐ 7-10	☐ 10+	☐ I don't know
3. Do you take all of your mediations as prescribed?	☐ Yes	☐ Sometimes		☐ Almost never	
	☐ No	☐ I don't take medication			
4. How is the health of your mouth and teeth?	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ I don't know
5. Do you have a dentist that you visit regularly?	☐ Yes	☐ No		☐ I don't know	
6. How many times in the last six months have you been to the emergency room?	☐ 0	☐ 1-2	☐ 3-4	☐ 5+	☐ I don't know
7. How many times in the last six months were you admitted to the hospital?	☐ 0	☐ 1-2	☐ 3-4	☐ 5+	☐ I don't know

NUTRITION					
8. How many servings of fruits and vegetables do you usually eat each day?	☐ None	☐ 1-2	☐ 3-4	☐ 5+	☐ I don't know
9. 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
10. 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
11. 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
12. How many servings of sugar-sweetened drinks do you usually have each day?	☐ None	☐ 1-2	☐ 3-4	☐ 5+	☐ I don't know

SLEEP					
13. How many hours of sleep do you usually get?	☐ 0-3	☐ 4-6	☐ 7-10	☐ 10+	☐ I don't know
14. Do you snore or has anyone told you that you snore?	☐ Yes	☐ No	☐ I don't know		
15. In the past seven days, how often have you felt sleepy during the daytime?	☐ Often	☐ Sometimes		☐ Almost never	
	☐ Never	☐ I don't know			

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FUNCTIONAL STATUS ASSESSMENT, CPT II CODE 1170F

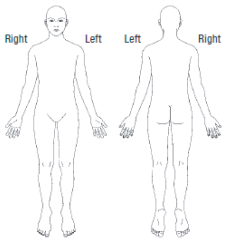
Instrumental activities of daily living		
16. Which of the following can you do on your own without help?	☐ Shop for groceries ☐ Use the telephone ☐ Housework ☐ Handle finances	☐ Drive/use public transport ☐ Make meals ☐ Take medications ☐ None
Activities of daily living		
17. Which of the following can you do on your own without help?	☐ Bath ☐ Dress ☐ Eat ☐ Walk ☐ Transfer (in/out of chairs, etc.) ☐ Use the restroom ☐ None	
18. Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?	☐ Yes ☐ No ☐ I don't know	
Ambulation status		
19. How long can you walk or move around?	☐ 0-5 min. ☐ 5-15 min. ☐ 15-30 min. ☐ More than 1 hour ☐ I don't know	
20. Which of these assistive devices do you use?	☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Other ☐ None	
21. Do you have trouble with your balance?	☐ Yes	☐ No
22. Have you fallen in the last six months?	☐ Yes	☐ No
Sensory ability		
23. Do you have problems with vision?	☐ Yes ☐ No	☐ I don't know
24. Do you use eyeglasses or contact lenses?	☐ Yes ☐ No	☐ I don't know
25. Do you have problems with hearing?	☐ Yes ☐ No	☐ I don't know
26. Do you use hearing aids or other devices to help you hear?	☐ Yes ☐ No	☐ I don't know

PAIN ASSESSMENT, CPT II CODES 1125F, 1126F

27. In the past two weeks, how often have you felt pain?
- ☐ Almost all of the time
- ☐ Most times
- ☐ Sometimes
- ☐ Almost never
- ☐ No pain

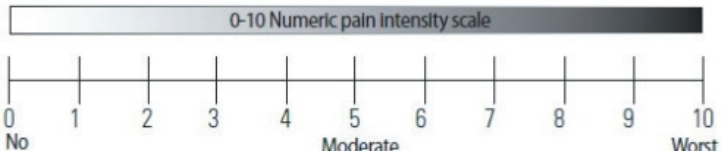
28. Where is the pain?

☐ No pain
or
Mark all areas indicated on the image



29. How do you treat the pain?
- ☐ Medication
- ☐ Rest
- ☐ Heat or cold
- ☐ Therapy
- ☐ Other
- ☐ No treatment plan
- ☐ No pain

30. Rate your pain on a scale of 0-10 with 0 being no pain and 10 being the worst pain:
Circle the number on the scale



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HOME/SAFETY

31. 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/home	
	☐ I don't have a place to live		☐ Other	
32. Does your home have working smoke alarms?	☐ Yes	☐ No	☐ I don't know	☐ NA
33. Do you fasten your seatbelt in vehicles?	☐ Yes	☐ No	☐ I don't ride in vehicles	

DEPRESSION – (PHQ-9), HCPCS CODE G0444

In the last two weeks, how often have you been bothered by any of the following problems?

34. Little interest or pleasure in doing things.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
35. Feeling down, depressed, or hopeless.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
36. Trouble falling or staying asleep or sleeping too much.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
37. Feeling tired or having little energy.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
38. Poor appetite or overeating.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
39. Feeling bad about yourself or that you're a failure or have let yourself or your family down.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
40. Trouble concentrating on things, such as reading the newspaper or watching television.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
41. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you've been moving around a lot more than usual.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
42. Thoughts that you would be better off dead or of hurting yourself.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
43. If you checked off any problems in this section, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not at all	☐ Somewhat	☐ Very difficult	☐ Extremely difficult

SOCIAL/EMOTIONAL SUPPORT

44. 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	
45. How often do you get out and meet with family and friends?	☐ Often	☐ Sometimes	☐ Almost never	☐ None

ADVANCE DIRECTIVES, CPT II CODES 1157F, 1158F; HCPCS CODE S0257

46. Do you have a health care power of attorney or a living will?	☐ Yes	☐ No	☐ I don't know
47. Would you like more information?	☐ Yes	☐ No	