



MEDICARE WELLNESS CHECKUP

Health Risk Assessment

Please complete this form and bring it with you to your visit.

Your name: _____

Today's date: _____ Your date of birth: _____

If this is your first visit with this Doctor, please bring the following:

- Your current medical and immunization records
- Your family health history
- A list of current doctors and other health service providers

1. Over the past two weeks, how often have you been bothered by any of the following problems?

- Feeling down, depressed or hopeless
- Not at all More than half the days
- Several days Nearly daily

- Little interest or pleasure in doing things
- Not at all More than half the days
- Several days Nearly daily

2. Highest level of Education:

Completed High School, or Higher

Did not complete High School

3. In the last 7 days, did you have difficulty performing the following self-care activities?

- | | | |
|--|------------------------------|-----------------------------|
| Eating | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Getting dressed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Grooming | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Walking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Using the toilet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Getting in and out of bed or chair | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Controlling urge to go to the bathroom | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shopping | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Preparing food | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Housekeeping | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Doing laundry | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Handling finances | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Going places | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Using the telephone | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Managing medications | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

4. Have you experienced a fall in the last year?

Yes No

If yes, how many times have you fallen this year? _____

5. Were you injured in the fall(s)?

Yes No

6. How intense is your typical physical activity or exercise?

Light (such as stretching or slow walking)

Moderate (such as brisk walking)

Heavy (such as jogging or swimming)

Very heavy (such as fast running or stair climbing)

I am not currently exercising

7. Please indicate if you have any of the following in your home:

Smoke detectors Yes No

Firearms Yes No

Carbon monoxide detectors Yes No

Radon Yes No Unknown

↳ If yes treated untreated

8. Do you use your seatbelt in a vehicle? Yes No

9. What do you use for heating your home?

Coal Yes No

Electric Yes No

Gas Yes No

Oil Yes No

Solar Yes No

Wood Yes No

10. Generally, how would you describe your diet?

- | | | |
|--------------|------------------------------|-----------------------------|
| Diabetic | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gluten Free | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Healthy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Calorie | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High fat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Salt | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Junk food | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Low calorie | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Low fat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Low salt | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| No red meat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vegan | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vegetarian | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

11. Do you take any of the following OTC vitamins or supplements?

- | | | |
|--------------|------------------------------|-----------------------------|
| Calcium | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Multivitamin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vitamin D | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Folic Acid | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Continued on other side

12. Do you use tobacco currently?
 Yes No
If no, have you ever used tobacco? Yes No
If yes, what kind and how much? _____

13. Are you or have you been exposed to secondhand smoke?
 Yes No

14. Do you drink any alcoholic beverages?
 Yes No
If no, when was your last drink? _____

If yes, how often and what type? _____

15. Are there any changes or updates to your medical history?
 Yes No
If yes, please list _____

16. Have you had your vision checked?
 Yes No
If yes, who and when? _____
If no, would you like a referral? Yes No

17. Has anyone expressed concern about your hearing?
 Yes No

18. During the past 12 months, have you experienced confusion or memory loss that is happening more often or is getting worse?
 Yes No

19. Do you have a family history of psychiatric problems?
 Yes No

20. Do you have a history of psychiatric problems?
 Yes No

21. Do you have any sexual practice concerns and or drug use concerns?
 Yes No

22. Is there or has anyone ever forced you into sexual activities that made you feel uncomfortable?
 Yes No

23. Have you ever been physically hurt, slapped, kicked or threatened to be hurt by anyone?
 Yes No

24. Are you sexually active?
 Yes No
If yes, do you practice safe sex? Yes No

25. Do you have any Advanced Directives in place? Advanced Directives (Durable Power of Attorney for Healthcare) are documents that can help ensure your wishes are followed in the instance you cannot make your own medical decisions.
 Yes No
If yes, please bring a copy with you so that we can add it to your record.
If no, would you like some information?
 Yes No

26. What is your race? Please check all that apply.
 White
 Black or African American
 Asian
 Native Hawaiian or Other Pacific Islander
 American Indian or Alaskan Native
 Hispanic or Latino origin or descent
 Other
 Declined

27. Please list **all** health care providers that you see.
Please list provider name, office location, and type of provider (for example, "cardiologist").

28. Which companies do you mainly use to get durable medical supplies and equipment prescribed by your doctor?
For example: CPAP machine, diabetic testing supplies, wheelchair or cane, etc.

