MEDICARE WELLNESS CHECKUP

Health Risk Assessment

Your Name: _____

Today's date: _____

Your date of birth: _____

Please complete this form

Bring this form with you to your visit

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. In the last two weeks, how often have you felt down, depressed or hopeless?
☐ Yes ☐ No

2. In the last two weeks, how often have you felt little interest or pleasure doing things?
☐ Yes ☐ No

3. Highest level of Education:
☐ Complete High School, or Higher
☐ did not complete High School

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

Eating	☐ Yes	☐ No
Getting dressed	☐ Yes	☐ No
Grooming	☐ Yes	☐ No
Bathing	☐ Yes	☐ No
Walking	☐ Yes	☐ No
Using the toilet	☐ Yes	☐ No

5. Have you fallen in the last year?
☐ Yes ☐ No

6. If yes (to number 5 question), did the fall result in injury?
☐ Yes ☐ No

7. How intense was 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

8. 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:	☐ treated	☐ untreated

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

10. 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

11. Generally, how would you describe your diet?

Diabetic	☐ Yes	☐ No
Gluten Free	☐ Yes	☐ No
Healthy	☐ Yes	☐ No
High Calorie	☐ Yes	☐ No
High fat	☐ Yes	☐ No
High Salt	☐ Yes	☐ No
Junk food	☐ Yes	☐ No
Low calorie	☐ Yes	☐ No
Low fat	☐ Yes	☐ No
Low salt	☐ Yes	☐ No
No red meat	☐ Yes	☐ No
Vegan	☐ Yes	☐ No
Vegetarian	☐ Yes	☐ No

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

Calcium	☐ Yes	☐ No
Multivitamin	☐ Yes	☐ No
Vitamin D	☐ Yes	☐ No
Folic Acid	☐ Yes	☐ No

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

_____

14. Are you or have you been exposed to 2nd hand smoke?
☐ Yes ☐ No

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

_____

If yes, when and what type? _____

_____

16. Are there any changes or updated to your medical history?
☐ Yes ☐ No
If yes, please list _____

_____

_____

17. Do you see anyone for your Vision?
☐ Yes ☐ No
If yes, who and when? _____
If no, would you like a referral? ☐ Yes ☐ No

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

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

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

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

22. Have you ever been physically hurt, slapped, kicked or threated to be hurt by anyone?
☐ Yes ☐ No

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

24. Do you have any Advanced Directives in place?
☐ 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

25. 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