IHA

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	☐ Yes	☐ No
Getting dressed	☐ Yes	☐ No
Grooming	☐ Yes	☐ No
Bathing	☐ Yes	☐ No
Walking	☐ Yes	☐ No
Using the toilet	☐ Yes	☐ No
Getting in and out of bed or chair	☐ Yes	☐ No
Controlling urge to go to the bathroom	☐ Yes	☐ No
Shopping	☐ Yes	☐ No
Preparing food	☐ Yes	☐ No
Housekeeping	☐ Yes	☐ No
Doing laundry	☐ Yes	☐ No
Handling finances	☐ Yes	☐ No
Going places	☐ Yes	☐ No
Using the telephone	☐ Yes	☐ No
Managing medications	☐ Yes	☐ No

4. Do you feel unsteady when standing or walking?
☐ Yes ☐ No

5. Have you experienced a fall in the last year?
☐ Yes ☐ No
If yes, how many times have you fallen this year? _____

6. Were you injured in the fall(s)?
☐ Yes ☐ No

7. 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

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	☐ Yes	☐ No	☐ Unknown
↳ *If yes*	☐ 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

13. In general, how would you say your health is?
☐ Excellent ☐ Very good ☐ Good
☐ Fair ☐ Poor

Continued on other side

14. Do you have any teeth or dental problems?
☐ Yes ☐ No

15. Over the past two weeks, have you experienced unusual tiredness or fatigue?
☐ Yes ☐ No

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

_____

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

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

_____

If yes, how often and what type? _____

_____

19. In the past year, how often have you used the following?

Alcohol (For men, 5 or more drinks a day. For women, 4 or more drinks a day.)
☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly
☐ Daily or Almost Daily

Tobacco Products
☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly
☐ Daily or Almost Daily

Prescription Drugs for Non-medical Reasons
☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly
☐ Daily or Almost Daily

Illegal Drugs
☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly
☐ Daily or Almost Daily

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

_____

21. Has there been any cancer, heart attack or stroke diagnosed amongst your family members?
☐ Yes ☐ No
If yes, please list _____

_____

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

23. Has anyone expressed concern about your hearing?
☐ Yes ☐ No

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

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

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

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

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

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

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

31. 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

32. 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

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

_____

_____

34. 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.

_____

_____