UB|MD INTERNAL MEDICINE

Medicare Annual Wellness Visit Health Risk Assessment

PATIENT NAME	BIRTH DATE / /
	DATE OF VISIT / /

In general, would you say your health is: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor			
The date of your last: Dental visit: _____ Eye exam: _____			
In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? _____ (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables or 1 medium piece of fruit, 1 cup is approximately the size of a baseball.)			
In the past 7 days, how many servings of high-fiber or whole-grain foods did you typically eat each day? _____ (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, ½ cup of cooked brown rice or whole wheat pasta.)			
In the past 7 days, how many sugar-sweetened beverages (such as soda/pop – this **does not** include fruit juices) did you typically consume each day? _____			
Without wanting to, have you lost 10 pounds or more in the past 2 months?	☐ Yes	☐ No	
In the past 7 days, how many days did you exercise? _____			
On days when you exercised, for how many minutes did you exercise? _____			
How fast do you feel you can walk?	☐ Slow	☐ Medium	☐ Fast
How much energy do you feel you have?	☐ Low	☐ Medium	☐ High
How many hours of sleep do you usually get each night? _____			
Do you:			
Live alone?	☐ Yes	☐ No	
Feel safe in your home?	☐ Yes	☐ No	
Use sunscreen?	☐ Yes	☐ No	
Drive?	☐ Yes	☐ No	
Wear seatbelts?	☐ Yes	☐ No	
Feel afraid of falling?	☐ Yes	☐ No	
Have you fallen within the past year?	☐ Yes	☐ No	
Use tobacco produces	☐ Yes	☐ No	
If yes, are you interested in quitting?	☐ Yes	☐ No	
If you used tobacco products in the past, what year did you quit? _____			
Use recreational (street) drugs?	☐ Yes	☐ No	
Have a caregiver?	☐ Yes	☐ No	
Are you:			
A caregiver?	☐ Yes	☐ No	

Do you have the following in your home?		
Stairs?	☐ Yes	☐ No
Area rugs?	☐ Yes	☐ No
Smoke detectors?	☐ Yes	☐ No
Carbon monoxide detectors?	☐ Yes	☐ No
Pets?	☐ Yes	☐ No
Unsecured firearms?	☐ Yes	☐ No
In the past 7 days, on how many days did you drink alcohol? _____		
If you drink alcohol, how many times in the past year did you have 3 or more drinks on one occasion? _____		
In the past 2 weeks, have you felt nervous or anxious on more than half the days?	☐ Yes	☐ No
Has stress been a problem for you in handling such things as your health, finances, family, social relationships or work on more than half the days?	☐ Yes	☐ No
In the past 2 weeks, has anger interfered with your relationships with others on more than half the days?	☐ Yes	☐ No
Do you feel that you get the social support that you need?	☐ Yes	☐ No
In the past 7 days, how much pain have you felt?	☐ None ☐ Some	☐ A lot

Activities of Daily Living	Do you need help with any of the following?		If yes, do you have the help you need?		
Preparing your own meals	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Shopping	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Paying bills or managing checkbook	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Housework/laundry	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Using phone	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Transportation in community	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Travelling by train/bus/plane	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Taking medications	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Moving from bed to chair	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Feeding yourself	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Dressing	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Bathing	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Grooming	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Using the toilet	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A

PHQ-2

Please complete the following information about yourself.

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1) Little interest or pleasure in doing things: ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

2) Feeling down, depressed, or hopeless: ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

SIGNATURE

_____ _____

Signature **Date**

If completed by someone other than the patient:

Your Name:_____ **Relationship:**_____