Name: «FirstName» «LastName» Date of Birth: «DOB» Date of Service: __________

Medicare Annual Wellness Visit - Health Risk Assessment

General Health

1. How is your overall health
   a. Excellent
   b. Good
   c. Fair
   d. Poor
   e. I don't know
2. How is the health of your mouth and teeth?
   a. Excellent
   b. Good
   c. Fair
   d. Poor
   e. I don't know
3. In the past 6 months, how many times have you been seen in the emergency room?
   a. 0
   b. 1-2
   c. 3-4
   d. 5+
   e. I don't know
4. In the past 6 months, how many times have you been admitted to the hospital
   a. 0
   b. 1-2
   c. 3-4
   d. 5+
   e. I don't know
5. In the past 2 weeks, have you experienced any of the following?
   a. Unexplained weight loss
   b. Change in appetite
6. Do you have problems with vision?
   a. Yes, I use ____contact lenses ____glasses
   b. Yes and I do not use contact lenses or glasses
   c. No
7. Do you have problems with hearing
   a. Yes and I use hearing devices to help me hear
   b. Yes and I do not use hearing devices to help me hear
   c. No
8. Please list any specialty or other care providers that participate in your healthcare

Specialty	Provider Name
Cardiologist	

Name: «FirstName» «LastName» Date of Birth: «DOB» Date of Service: ____________

Pulmonologist	
Endocrinologist	
Gynecologist	
Dermatologist	
Ear, Nose, Throat	
Eye Doctor	
Dentist	
Physical Therapist	
Other:____________	

Activities of Daily Living

1. In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your own medications?
   a. Yes, please explain____________
   b. No
2. In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking or using the toilet?
   a. Yes, please explain____________
   b. No

Functional Ability

1. How long can you walk or move around before needing a break?
   a. 0-5 minutes
   b. 5-15 minutes
   c. 15-30 minutes
   d. 30 minutes to 1 hour
   e. Longer than 1 hour
2. Do you use any of the following devices?
   a. Cane
   b. Walker
   c. Crutches
   d. Wheelchair
   e. I do not use any of these
3. Do you have problems with balance?
   a. Yes
   b. No
4. Have you fallen in the last 6 months?
   a. Yes
   b. No