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AHWATUKEE/SUN LAKES/GILBERT

MEDICARE ANNUAL WELLNESS HEALTH RISK ASSESSMENT

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Please complete this Medicare Annual Wellness Visit Health Risk Assessment Form so we may better help you with your healthcare needs.

GENERAL HEALTH ASSESSMENT

In general, how would you rate your overall health? ☐Poor ☐Fair ☐Good ☐Very Good ☐Excellent

In general, how satisfied are you with your life? ☐Very Satisfied ☐Satisfied ☐Dissatisfied ☐Very Dissatisfied

How is your physical activity compared to one year ago? ☐Same ☐Increased ☐Decreased

Do you have any of the following: ☐Living Will ☐Advanced Directives ☐Medical Power of Attorney

Please let us know if you would like information about these.

HOME SAFETY ASSESSMENT

Where do you live? ☐ your own home/apartment ☐ independent living facility ☐ assisted living/nursing facility ☐ I am homeless

With whom do you live? ☐alone ☐spouse ☐family ☐friend/roommate ☐group home residents

Do you feel safe in your home or residence? ☐Yes ☐No

Are emergency numbers stored in your phone or wallet & regularly updated? ☐Yes ☐No

Do you have a working fire extinguisher and smoke detectors in your home? ☐Yes ☐No

Do you have an emergency exit plan and alternate exit plan in case of fire? ☐Yes ☐No

If you have firearms in your home, are they stored unloaded & securely locked? ☐Yes ☐No ☐N/A

Do you always fasten your seat belt when you are driving? ☐Yes ☐No

ACTIVITIES OF DAILY LIVING AND FUNCTIONAL CAPACITY

Do you need assistance with any of the following Activities of Daily Living?

☐Dressing	☐Bathing	☐Preparing food/meals
☐Walking	☐Shopping	☐Driving
☐Housekeeping	☐Handling finances	☐Managing medications

Have you experienced any problems with your memory or thinking? ☐Yes ☐No

Have any concerns been raised by others about your memory or thinking? ☐Yes ☐No

Do you have trouble with your hearing? ☐Yes ☐No

Do you wear a hearing aid/device? ☐Yes ☐No

Are you having problems with your vision? ☐Yes ☐No

Have you had problems using your teeth or dentures? ☐Yes ☐No

Have you had urine incontinence or leakage in the past 3 months? ☐Yes ☐No

Do you find it necessary to use some type of protection (pad or undergarments)? ☐Yes ☐No

PAIN ASSESSMENT

In the past 2 weeks, how often have you felt pain?

☐Never ☐Almost never ☐Sometimes ☐Most times ☐All of the time

If so, how severe is your pain on a scale of 1-10? _____

In the past 4 weeks, have you used prescription narcotic or opioid medications? ☐Yes ☐No

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NUTRITION AND EXERCISE ASSESSMENT

On a typical day, how many servings do you eat/drink of the following foods/beverages:

_____ Fruits and vegetables _____ High fiber or whole grain foods

_____ Fried or high fat foods _____ Caffeinated beverages

How many days a week do you usually exercise? _____

On days when you exercise, for how long do you usually exercise? _____minutes per day

How intense is your typical exercise?

- ☐ none – currently not exercising
- ☐ light (stretching/slow walking)
- ☐ moderate (brisk walking)
- ☐ heavy (jogging/swimming)
- ☐ very heavy (fast running/stair climbing)

SOCIAL AND BEHAVIORAL RISK ASSESSMENT

Over the past 2 weeks, how often have you been bothered by the following concerns:	**Not at All**	**Less Than Half the days**	**More Than Half the days**	**Nearly Every Day**
Had little or no pleasure in doing things	0	1	2	3
Felt down, depressed or hopeless	0	1	2	3

Do you feel that you are able to cope with stress in your life adequately? ☐Yes ☐No

Do you feel you get the social and emotional support you need? ☐Yes ☐No

Do you currently use tobacco or a smokeless tobacco product? ☐Yes ☐No

If yes: What products do you use? ☐cigarettes ☐cigars ☐chewing tobacco ☐e-cigarettes/vaping

Are you interested in quitting? ☐Yes ☐No

Are you a former smoker? ☐Yes ☐No If so, when did you quit? _____

Do you drink alcohol? ☐Yes ☐No If so, how may drinks per week? _____

Have you ever driven while intoxicated or rode with a driver who was intoxicated? ☐Yes ☐No

Have you used any illicit/illegal drugs? ☐Yes ☐No

Do you use marijuana or related substances? ☐Yes ☐No

FALL RISK PREVENTION

Have you had more than one fall in the past 12 months? ☐Yes ☐No

Were you injured from a fall over the past 12 months? ☐Yes ☐No

Are you feeling imbalanced or unsteady? ☐Yes ☐No

Do you use a mobility assist device (cane, walker, brace, wheelchair)? ☐Yes ☐No

Are rugs and electrical cords secured properly to prevent falls? ☐Yes ☐No

Do all stairways have a railing/banister? ☐Yes ☐No

Are doorways, halls, stairs, sidewalks and outdoor steps free of clutter? ☐Yes ☐No

Are non-slip mats or surfaces in all bathtubs & showers? ☐Yes ☐No

Do bathrooms have safety rails/grab bars? ☐Yes ☐No

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MEDICAL HISTORY UPDATE

Have any family members developed new medical concerns in the past 12 months:

Family Member (relation to you)	Medical concern:

Do you keep an updated list of your medications (including herbals and supplements)? ☐Yes ☐No

Have you developed any new food or medication allergies over the past year? ☐Yes ☐No

If so, please list: _____

Have you had any ER or hospital visits over the past year which we have not discussed? ☐Yes ☐No

If so, when did this happen and why: _____

_____

_____

LIST OF PROVIDERS, SUPPLIERS AND PHARMACIES

Please write down a list of the specialists whom you are currently seeing: (Please include physicians and alternative medicine providers such as chiropractors, dentists, optometrists, counsellors).

Name of Doctor or Specialist	Specialty

Where do you get your medical supplies/equipment? (diabetes, ostomy, prosthetics, CPAP, etc.)

Type of Equipment	Supplier

Please update your preferred pharmacies.

Local	Name:	Location:
Mail Order	Name:	