## MEDICARE WELLNESS VISIT PATIENT HEALTH RISK ASSESSMENT QUESTIONNAIRE (Pg 1)

**Name of Patient:** _____ **DOB:** _____
**Today's Date:** _____

**Do you have any health concerns or NEW complaints you would like to address today?** Yes _____ No _____

**Past Medical/Surgical History: (List illnesses, injuries, operations, hospitalizations, date and hospital)**

**Please list your current healthcare providers involved in your care and condition treated: (Specialists, Therapists, VNA, etc)**

**Are there any preventative tests you have done recently? (Lab tests, Mammograms, X-rays, etc.)**

**Have you had any recent immunizations?** Yes__ No __

**Do you have a Health Care Proxy?** Yes__ No __

**General Health and Social/Emotional Support:**

In general, would you say your health is: Excellent _____Very Good _____ Good _____ Fair _____ Poor _____

Does handling such things as your health, finances, family or social relationships or work cause you stress? Yes__ No __
Do you get the social and emotional support you need? Yes__ No __
Do you snore or has anyone told you that you snore? Yes__ No __
Do you always fasten your seatbelt when you are in a car? Yes__ No __

**Hearing Loss Screen:**

Do you have trouble hearing the television or radio when others do not? Yes__ No __
Do you have to strain or struggle to hear/understand conversations? Yes__ No __

**Function Screen:**

Do you live alone? Yes ___ No ___
Do you need help to shop? Yes ___ No ___
Do you need help to do light housework? Yes ___ No ___
Do you need help to walk across a room? Yes ___ No ___
Do you need help to take a bath/shower? Yes ___ No ___
Do you need help to manage the household finances? Yes ___ No ___
Do you need help to take your medications? Yes ___ No ___
Do you feel you have trouble with memory? *** Yes ___ No ___

**Home Safety Screen:**

Does your home have throw rugs, poor lighting, or a slippery bathtub/shower? Yes ___ No ___
Does your home have grab bars in the bathroom, handrails on the steps or stairs? Yes ___ No ___
Does your home have functioning smoke alarms? Yes ___ No ___

## MEDICARE WELLNESS VISIT PATIENT HEALTH RISK ASSESSMENT QUESTIONNAIRE (Pg 2)

**Name of Patient:** _____ **DOB:** _____
**Today's Date:** _____

**Social History:**

Do you use tobacco? Yes__ No __
Have you smoked 100 cigarettes in your lifetime? Yes__ No __
Do you use alcohol? Yes__ No __

**Sexual History: (optional)**

Have you had sex in the past 12 months? Yes ___ No ___
Have you had multiple partners? Yes ___ No ___
Have you used protection? Yes ___ No ___
Have you ever had an STD? Yes ___ No ___

**Alcohol Use:**

Did you have a drink containing alcohol in the past year? Yes ___ No ___
If yes, how often did you have a drink containing alcohol in the past year? Answer: _____
If yes, how often did you have a drink on a typical day when you were drinking in the past year? _____
If yes, how often did you have six or more drinks on one occasion in past year? _____

**Depression Screen:**

Over the past 2 weeks, have you felt down, depressed or hopeless? Yes__ No __
Over the past 2 weeks, have you felt little interest or pleasure in doing things? Yes__ No __
Over the past 2 weeks, have you had trouble falling or staying asleep, or sleeping too much? Yes__ No __
Over the past 2 weeks, have you been feeling tired or having little energy? Yes__ No __
Over the past 2 weeks, have you had a poor appetite or overeating? Yes__ No __
Over the past 2 weeks, have you been feeling bad about yourself-or that you are a failure or have let yourself or your family down? Yes__ No __
Over the past 2 weeks, have you had trouble concentrating on things, such as reading the newspaper or watching television? Yes__ No __
Over the past 2 weeks, have you been moving or speaking so slowly that other people could have noticed? or the opposite? being so fidgety or restless that you have been moving around a lot more than usual? Yes__ No __
Over the past 2 weeks, have you had thoughts that you would be better off dead, or of hurting yourself? Yes__ No __

**Form Completed by:**

_____

**Signature** **Relationship**

MEDICARE PREVENTATIVE SERVICES CHECKLIST

Talk with your doctor or other health care provider about which of these services are right for you. As part of your yearly "Wellness" visit, you may be asked to fill out a Health Risk Assessment to help you figure out what to work on to stay healthy. To learn more, visit www.medicare.gov.

| **Medicare-Covered Preventative Service** | **I need (Yes/No)** | **Date Last Received** | **Next Date Medicare Covers This Service** |
|---|---|---|---|
| "Welcome to Medicare": Preventative Visit (one-time) within first 12 months you have Medicare Part B | | | |
| Yearly "Wellness" Visit – 12 months after "Welcome to Medicare" visit or Part B effective date | | | |
| Abdominal Aortic Aneurysm Screening | | | |
| Bone Mass Measurement (Bone Density Test) | | | |
| Breast Cancer Screening (mammogram) | | | |
| Cardiovascular Screenings (cholesterol, lipids, triglycerides) | | | |
| Cervical and Vaginal Screenings | | | |
| Colorectal Cancer Screening | | | |
| Diabetes Screening | | | |
| Diabetes Self-Management Training | | | |
| Flu Shot | | | |
| Glaucoma Test | | | |
| Hepatitis B Shot | | | |
| HIV Screening | | | |
| Medication Nutrition Therapy Services | | | |
| Pneumococcal Shot | | | |
| Prostate Cancer | | | |
| Shingles Vaccine | | | |
| Tetanus Vaccine | | | |
| Tobacco Use Cessation Counseling | | | |

For some services, you will need to wait a certain amount of time before getting the service again. See page 27 of the Your Guide to Medicare's Preventative Services for more information.