Medicare's Annual Wellness Visit

Health Risk Assessment

Name _____

Date of Birth _____ Date _____

General Health	
Form completed by:	☐ Self ☐ Friend/Family ☐ Clinic Staff ☐ Other
How do you rate your overall health?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Do you have a dentist you see regularly?	☐ Yes ☐ No
How many times in the last six months have you been to the emergency room?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+
How many times in the last six months have you been admitted to the hospital?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+
Rate your pain on a scale of 0-10, where 0 means **no pain at all** and 10 means the **worst pain imaginable**.	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Medications	
Do you take any over-the-counter medications (vitamins, supplements, herbal medicines)?	☐ Yes ☐ No
How many times in the last month have you missed taking your medications?	_____ times ☐ I don't take medications
How many times in the last month have you taken your medications differently than prescribed by your doctor?	_____ times ☐ I don't take medications
Do you have enough money to pay for the medications, medical supplies, and medical visits you need?	☐ Yes ☐ No

Teton Valley Health Care

Physical Activity	
How many days a week do you exercise?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't exercise
On the days you exercised how long did you exercise?	☐ 0-30 min ☐ 30 min – 1 hour ☐ More than 1 hour ☐ I don't exercise
What kind of exercise routine do you have?	☐ Light (walking, stretching) ☐ Heavy (jogging, swim) ☐ Routine activities (cleaning, gardening, shopping) ☐ I don't exercise

Tobacco Use	
Do you use tobacco or nicotine products (cigarettes, e-cigarettes, smokeless tobacco, cigars or pipes)?	☐ Yes ☐ No If yes, how many packs/times per day? _____ How many years? _____
Are you interested in quitting?	☐ Yes ☐ No

Alcohol and Substance Use	
How often do you have a drink containing alcohol?	☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week
How many drinks containing alcohol do you have on a typical day?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+
How often do you have six or more drinks on one occasion?	☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
How many times, within the past year, have you used illegal drugs or used a prescription medication for nonmedical reasons?	_____ times ☐ I don't know

Hearing Loss	
Do you wear hearing aids?	☐ Yes ☐ No
Do you have trouble hearing the TV or conversations when others don't?	☐ Yes ☐ No
Do you or people around you have concerns about your hearing?	☐ Yes ☐ No

Sleep	
How many hours of sleep do you usually get?	☐ 0-3 ☐ 4-6 ☐ 7-10 ☐ 10+ ☐ I don't know
Do you snore or has anyone told you that you snore?	☐ Yes ☐ No ☐ I don't know
In the past 7 days how often have you felt sleepy during the daytime?	☐ Often ☐ Sometimes ☐ Almost never ☐ Never ☐ I don't know

STEADI Fall Risk	
Do you have any of the following increased fall risk factors? Please mark all that apply.	☐ Have you fallen in the last year? ☐ Do you use or have you been advised to use a cane or walker to get around safely? ☐ Do you sometimes feel unsteady while walking? ☐ Do you steady yourself by holding onto furniture when walking at home? ☐ Do you worry about falling? ☐ Do you need to push with your hands to stand up from a chair? ☐ Do you have trouble stepping up onto a curb or step? ☐ Do you often have to rush to the toilet? ☐ Have you lost some feeling in your feet? ☐ Do you take medication that sometimes makes you lightheaded or more tired than usual? ☐ Do you take medicine to help you sleep or improve your mood? ☐ Do you often feel sad or depressed?

Advance Care Planning	
Have you discussed who in your family would make decisions about the care you would want to receive if you become unable to speak for yourself?	☐ Yes ☐ No
Do you have a health care power of attorney, or a living will?	☐ Yes ☐ No
Would you be comfortable discussing this further with your provider today?	☐ Yes ☐ No

Other Health Care Providers	

Provider Name	Specialty

Screening and Immunizations	
Colorectal Cancer Screening	☐ Colonoscopy ☐ Cologuard ☐ FOBT/FIT ☐ Other Date_____ Result: ☐ Normal ☐ Abnormal Place of service _____
Breast Cancer Screening	Date_____ Result: ☐ Normal ☐ Abnormal
Immunizations	Influenza (flu): ☐ Yes (date _____) ☐ No COVID: ☐ Yes (date _____) ☐ No Pneumonia: ☐ Yes (date _____) ☐ No Shingles: ☐ Yes (date _____) ☐ No Tdap/TD: ☐ Yes (date _____) ☐ No
Eye Exam	Date_____ Result: ☐ Normal ☐ Abnormal
Osteoporosis Screening	History of fracture in the past 6 months? ☐ Yes ☐ No Date of last DEXA/Bone Density test completed? _____ Are you currently taking Osteoporosis medication? ☐ Yes ☐ No Medication name _____

Functional and Home Safety Screen	
What is your living situation?	☐ Alone ☐ With my spouse or other family ☐ Nursing Home ☐ With a friend or roommate ☐ Assisted Living ☐ Retirement Community ☐ I don't have a place to live ☐ Other
Do you have any concerns about meeting your basic needs (housing, food, utility bills)?	☐ Yes ☐ No

Which of the following can you do on your own without help?	☐ Shop for groceries ☐ Use the telephone ☐ Housework ☐ Handle finances ☐ Cook meals ☐ Take medicines ☐ Drive/use public transportation ☐ None of these
Which of the following can you do on your own without help?	☐ Bathe ☐ Dress ☐ Eat ☐ Walk ☐ Use Stairs ☐ Stand ☐ Use the toilet ☐ None of these

Do you need an assistive device to walk or move around?	☐ Yes ☐ No If yes, what type of device? ☐ Cane ☐ Wheelchair ☐ Walker ☐ Other
How many days of the week do you have physical pain that affects your activities?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7
Does your home have rugs, poor lighting, or slippery bathtub/shower?	☐ Yes ☐ No
Do you have grab bars in bathrooms, handrails on stairs or steps?	☐ Yes ☐ No
Do you have functioning smoke/carbon monoxide alarms?	☐ Yes ☐ No

Social Support	
Which of the following applies to you?	☐ I have a supportive family ☐ I have supportive friends ☐ I participate in church, clubs, or other activities ☐ None
Do you have transportation to medical appointments?	☐ Yes ☐ No
In the last 12 months, have you needed to see a doctor but could not because of cost?	☐ Yes ☐ No
Do you need help reading hospital or clinic material?	☐ Yes ☐ No
Do you or your caregiver have enough help with resources or caregiving duties? (skip if you do not give or receive care)	☐ Yes ☐ No
Is anyone mistreating you physically, or financially?	☐ Yes ☐ No
If you answered yes to any of these questions, would you like to receive assistance with any of these needs?	☐ Yes ☐ No

Your Medical History *(check if you have had any of the following conditions)*

- ☐ Alcoholism
- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Bladder Problems
- ☐ Blindness
- ☐ Blood Clots
- ☐ Breast Cancer
- ☐ Chronic Pain
  - ☐ Opioid Use
- ☐ COPD
- ☐ Colon Cancer/Polyps
- ☐ Cancer – Other
  - Type ___________________
- ☐ Depression
- ☐ Diabetes HbA1C
  - Date ___________________
- ☐ Diabetic Retinopathy
  - Date of Exam ___________
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Disease
  - ☐ Statin Therapy
- ☐ Heart Failure
- ☐ Hepatitis
- ☐ High Cholesterol
  - ☐ Statin Therapy
- ☐ Hypertension
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Physical Disability
- ☐ Seasonal Allergies
- ☐ Seizure Disorder
- ☐ Sleep Disorder
- ☐ Stomach Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcer

Your Family's Medical History *(check if a relative has had one of these problems)*

☐ Alcoholism	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Alzheimer's	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Dementia	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Breast Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Colon Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Prostate Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Cancer (Other)	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Diabetes	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Mental Illness	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Hypertension	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Heart Attack	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Osteoporosis	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Seizures	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Stroke	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling

Medications

*****Please bring a Ziplock bag containing all of your current medications with you to your appointment. This should include prescriptions, over the counter and vitamin supplements.*

Depression Screening *In the last two weeks, how often have you been bothered by any of the following problems? If answer to either question is yes, clinic will administer PHQ-9 and **provider** will address during visit.*	
Little interest or pleasure in doing things?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling down, depressed or hopeless?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Trouble falling, staying asleep or sleeping too much?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling tired or having little energy?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Poor appetite, weight loss or overeating?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling bad about yourself – or that you are a failure, or that you have let yourself or your family down?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Trouble concentrating on things like schoolwork, reading or watching TV?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Thoughts that you would be better off dead or of hurting yourself in some way?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day