Medicare Annual Wellness Visit
Required Patient Health Risk Assessment

Patient Name:____________________ Date of Birth__________  Todays Date:________

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health care possible.

1. What is your age?
   ☐ 65-69  ☐ 70-79  ☐ 80 or older

2. Are you a male or a female?
   ☐ Male  ☐ Female

3. During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?
   ☐ Not at all  ☐ Slightly  ☐ Moderately  ☐ Quite a bit  ☐ Extremely

4. During the past four weeks, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?
   ☐ Not at all  ☐ Slightly  ☐ Moderately  ☐ Quite a bit  ☐ Extremely

5. During the past four weeks, how much bodily pain have you generally had?
   ☐ No pain  ☐ Very mild pain  ☐ Mild pain  ☐ Moderate pain  ☐ Severe pain

6. During the past four weeks, was someone available to help you if you needed and wanted help?
   (For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)
   ☐ Yes, as much as I wanted  ☐ Yes, Quite a bit  ☐ Yes, some  ☐ Yes, a little  ☐ No, not at all

7. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?
   ☐ Very heavy  ☐ Heavy  ☐ Moderate  ☐ Light  ☐ Very light

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)
   ☐ Yes  ☐ No

9. Can you go shopping for groceries or clothes without someone’s help?
   ☐ Yes  ☐ No

10. Can you prepare your own meals?
    ☐ Yes  ☐ No

11. Can you do your housework without help?
    ☐ Yes  ☐ No

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
    ☐ Yes  ☐ No

13. Can you handle your own money without help?
    ☐ Yes  ☐ No

14. During the past four weeks, how would you rate your health in general?
    ☐ Excellent  ☐ Very good  ☐ Good  ☐ Fair  ☐ Poor

15. How have things been going for you during the past four weeks?
    ☐ Very well; could hardly be better  ☐ Pretty well  ☐ Good and bad parts about equal  ☐ Pretty bad  ☐ Very bad; could hardly be worse

Continued »
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16. Are you having difficulties driving your car?
   ☐ Yes, often
   ☐ Sometimes
   ☐ No
   ☐ Not applicable, I do not use a car

17. Do you always fasten your seat belt when you are in a car?
   ☐ Yes, usually
   ☐ Yes, Sometimes
   ☐ No

18. How often during the past four weeks have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falling or dizzy when standing up</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Sexual problems</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Trouble eating well</td>
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<tr>
<td>Teeth or denture problems</td>
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<tr>
<td>Problems using the telephone</td>
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<tr>
<td>Tiredness or fatigue</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

19. Have you fallen two or more times in the past year?
   ☐ Yes ☐ No

20. Are you afraid of falling?
    ☐ Yes ☐ No

21. Are you a smoker?
    ☐ No
    ☐ Yes, and I might quit
    ☐ Yes, but I’m not ready to quit

22. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?
    ☐ 10 or more drinks per week
    ☐ 6-9 drinks per week
    ☐ 2-5 drinks per week
    ☐ One drink or less per week
    ☐ No alcohol at all

23. Do you exercise for about 20 minutes three or more days a week?
    ☐ Yes, most of the time
    ☐ Yes, some of the time
    ☐ No, I usually do not exercise this much

24. Have you been given any information to help you with the following:
    Hazards in your house that might hurt you?
    ☐ Yes ☐ No
    Keeping track of your medications?
    ☐ Yes ☐ No

25. How often do you have trouble taking medicines the way you have been told to take them?
    ☐ I do not have to take medicine
    ☐ I always take them as prescribed
    ☐ Sometimes I take them as prescribed
    ☐ I seldom take them as prescribed

26. How confident are you that you can control and manage most of your health problems?
    ☐ Very confident
    ☐ Somewhat confident
    ☐ Not very confident
    ☐ I do not have any health problems

27. What is your race? (Check all that apply)
    ☐ White
    ☐ Black or African American
    ☐ Asian
    ☐ Native Hawaiian or other Pacific Islander
    ☐ American Indian or Alaskan Native
    ☐ Hispanic or Latino Origin or descent
    ☐ Other

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Patient Signature: ________________________________

Provider Signature: ________________________________

Date: ________________________

Date: ________________________