

# Annual Wellness Visit—Health Risk Assessment (Large Font)

Your name: \_\_\_\_\_ Today's date: \_\_\_\_\_  
Your date of birth: \_\_\_\_\_

Please fill out this form before seeing your doctor or nurse. Your answers will help you get the best possible health care.

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 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

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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 your 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 that are farther than walking distance without help? (For example, can you travel alone or 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

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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

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16. Are you having difficulties driving your car?

- Yes, often
- Sometimes
- No
- 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?

	Never	Seldom	Sometimes	Ofetn	Always
Falling or dizzy when standing up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble eating well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth or denture problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems using the telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Have you fallen two or more times in **the past year**?

- Yes
- No

20. Are you afraid of falling?

- Yes
- No

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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 the house that might hurt you?

- Yes
- No

Keeping track of your medications?

- Yes
- No

25. How often do you have trouble taking medications 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

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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 Health Risk Assessment. Please give the completed form to your doctor or nurse for your Medicare Wellness visit.