

MEDICARE HEALTH RISK ASSESSMENT

In order for Medicare to pay for a wellness physical the patient MUST complete a Health Risk Assessment form. If you need assistance, our staff will be happy to help you.

NAME _____ DOB: _____

EXERCISE

Type _____
How often? _____ How long each time? _____

DIET

On an average day, how many servings of the following do you eat?

Fruits _____ Dairy _____
Vegetables _____ Fiber _____

In an average week, how many servings of the following do you eat?

Red meat (beef/pork) _____
Chicken _____
Fish _____
Fried foods _____
Fast food _____
Restaurant _____

Do you take supplements?

Calcium _____
Vitamin D _____
Multivitamin _____
Other - please list _____

ALCOHOL

How many drinks per day? _____ OR per week? _____

Have you drunk more heavily in the past? Y N

TOBACCO

Do you smoke currently? Y N If yes, how much? _____

Have you smoked in the past? Y N Quit when? _____

Have you ever chewed tobacco or used snuff? Y N

When? _____ How much? _____

(over)

SAFETY

Auto - Do you drive? Y N
Do you wear a seat belt? Always Sometimes Never
Do you drive after drinking or ride with a driver who has
been drinking? Y N

Sun - Do you wear sunscreen? Always Sometimes Never

Home - Do you use stairs in your home? Y N
Are there throw rugs or other things you could trip on in
your home? Y N
Are there grab bars in your shower? Y N

SELF CARE

Do you have problems with your vision? Y N
Last eye doctor appointment _____ How often? _____
Last dental appointment _____
Do you have hearing problems? Y N Wear hearing aids? Y N
Do you have problems doing things with your hands (i.e., buttoning,
cooking, cleaning) Y N
Do you have balance problems? Y N
Have you fallen in the past year? Y N

Do you feel depressed or sad? Y N
Do you feel anxious? Y N

Are you having problems with your memory? Y N
Do you have a living will? Y N
Have you named a Medical Power of Attorney? Y N
Have you discussed your wishes for what happens to you if you can't
communicate (had a stroke or been in an accident)? Y N

SOCIAL

Do you live: alone___ w/family ___ w/friends ___
assisted living ___ nursing home ___

Do you feel safe where you live? Y N
Do you feel you can count on family or friends to help you? Y N
Do you need help handling your medications? Y N
Do you need help handling your money? Y N