

MEDICARE HEALTH RISK & SCREENING TOOL

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

Patient Name: _____ **Birth Date:** _____

EXERCISE: Type: _____

How Often? _____ How long each time? _____

DIET: On average per 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) _____ servings per week
Chicken _____ servings per week
Fish _____ servings per week
Fried Foods _____ servings per week
Fast Food _____ servings per week
Restaurant _____ servings per week

Do you take supplements?

Calcium _____ Yes _____ No _____ How many units/milligrams
Vitamin D _____ Yes _____ No _____ How many units/milligrams
Multi-Vitamin _____ Yes _____ No _____
Other (Please list) _____

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

Have you drunk more heavily in the past? _____ Yes _____ No

TOBACCO: Do you currently smoke? _____ Yes _____ No If yes, how much? _____

Have you smoked in the past? _____ Yes _____ No If yes, when did you quit? _____

Have you ever chewed tobacco or used snuff? _____ Yes _____ No If yes, when? _____ how much? _____

AUTOMOBILE: Do you drive? _____ Yes _____ No

Do you wear a seat belt? _____ Yes _____ No

Do you drive after drinking or ride with a driver who has been drinking? _____ Yes _____ No

SUN: Do you wear sunscreen? _____ Always _____ Sometimes _____ Never

SELF CARE:

Do you have problems with your vision? _____ Yes _____ No
Last eye doctor appointment _____ How often? _____
Last dental appointment _____

Do you have trouble hearing the television or radio when others do not? _____ Yes _____ No
Do you have to strain or struggle to hear or understand conversation? _____ Yes _____ No

In the last month, have you felt down, depressed, and hopeless? _____ Yes _____ No
In the last month, have you lost interest or pleasure in doing things you usually like to do? _____ Yes _____ No

In the past year have you had 2 or more falls? _____ Yes _____ No
In the past year have you fallen which resulted in an injury? _____ Yes _____ No

Do you have problems doing things with your hands such as buttoning, cooking, cleaning? _____ Yes _____ No

Are you having problems with your memory? _____ Yes _____ No

Do you have a living will? _____ Yes _____ No

Have you named a Medical Power of Attorney? _____ Yes _____ No

Have you discussed your wishes for what happens to you if you can't communicate? (I.e. had a stroke or been in an accident?) _____ Yes _____ No

SOCIAL: Do you feel safe where you live? _____ Yes _____ No

Do you feel you can count on family or friends to help you? _____ Yes _____ No

Sleep:

Do you feel you have problems with sleep, snoring or day time sleepiness? ___ yes ___ no

Would you like to speak with us about this? ___ yes ___ no

LIST OTHER PROVIDERS RENDERING YOU CARE: _____

COGNITIVE SCREEN: Draw a clock face, including all the numbers. Place the hands on the clock to read 4:10.

PATIENT TO LEAVE THE BELOW BLANK. TO BE COMPLETED BY THE PROVIDER. RECALL 3 UNRELATED ITEMS

- 1. _____
- 2. _____
- 3. _____

PROVIDER SIGNATURE: _____ **DATE:** _____