PIEDMONT INTERNAL MEDICINE

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 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 wished 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: _____