

Medicare Wellness Visit Health Risk Assessment

Today's Date: _____ **Patient Name:** _____ **DOB:** _____

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| In general, would you say your health is | Excellent Very Good Good Fair Poor |
| What matters most to you regarding your health? Please explain: | |
| Are you concerned about your vision? | Yes No |
| Are you concerned about your hearing? | Yes No |
| How would you describe the condition of your mouth and teeth—including false teeth or dentures? | Excellent Very Good Good Fair Poor |
| Do you or your family members have any concerns about your memory? Yes No | |
| If yes, please explain: | |
| Medications | |
| * Have you started taking any new medications or had changes to your medications since your last visit with us? | Yes No If yes, List new medications: |
| Tobacco and Alcohol Use | |
| * Have you ever used any tobacco products? (Cigarettes, chew, snuff, pipes, cigars, e-cigarettes, vaping) | Yes If yes, type of tobacco product: No |
| * If currently or previously used tobacco, how many cigarettes/ packs per day? | Usage per day: Years Used: Quit date: |
| * Are you interested in quitting tobacco? | Yes No |
| * Do you drink alcohol? | Yes If yes, frequency: Occasionally Daily No |

Fall Risk

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| * Do you use assistive devices to walk? If yes, which of these assistive devices do you use? | Please circle all that apply Cane Walker Wheelchair Crutches Other None |
| * Have you had any falls in the last year? | Yes No |

Activities of Daily Living

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| * In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet? | Yes (If yes, please explain) No |
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Instrumental Activities of Daily Living

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| In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications? | Yes (If yes, please explain) No |
| Does someone help you at home? | Yes No If yes, please provide Caregiver Name and relationship: |

Advance Directives

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| Do you have a person to make medical decisions for you in case you can't make them yourself? Yes No | |
| If yes please provide name, relationship and contact details: (Medical Power of Attorney) | |
| If you have any of the following, it would be helpful to have a copy provided to us for your medical record. | <ul style="list-style-type: none"> • Yes, I have a living will • Yes, I have a power of attorney • Yes, I have a POLST • Other: • No, I don't have any advance care planning documents |
| Would you like more information about Advance Care planning? | Yes No Unsure |