Middletown Valley Family Medicine

MEDICARE VISIT HEALTH RISK ASSESSMENT

(FOR ANNUAL AND SUBSEQUENT WELL VISITS ONLY)

Patient Name: ____ Date of Birth: ___________________________

Please complete this checklist before seeing your doctor or nurse. Your response will help you receive the best health and health care possible.

1. **What is your age?**
   - ☐ Under 65
   - ☐ 65-69
   - ☐ 70-79
   - ☐ 80 or older

2. **Are you a male or female?**
   - ☐ Male
   - ☐ Female

3. **During the *past four weeks*, how much have you been bothered by emotional problems, such as 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

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 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 out of walking distance without help? (For example, can you travel alone 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

16. **Are you having difficulties driving your car?**
    - ☐ Yes, often
    - ☐ Sometimes
    - ☐ No
    - ☐ Not applicable, I do not use a car

17. **Do you always fasten your seatbelt 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	Often	Always
Falling or dizzy when standing up					
Sexual Problems					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					
Tiredness or fatigue					

19. **Have you fallen two or more times in the past year?**
    - ☐ Yes
    - ☐ No

20. **Are you afraid of falling?**
    - ☐ Yes
    - ☐ No

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
    - ☐ 1 drink or less per week
    - ☐ No alcohol at all

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23. Do you exercise for about 20 minutes three or more times per week?
- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ No, I usually do not exercise this much

24. How often do you have trouble taking medicines 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

25. 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

26. 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

____
Print Name of Person Completing Form

____
Relationship to Patient (Note if Self)

____
Signature of Person Completing Form

____
Date

***For Middletown Valley Family Medicine Use Only*: The contents in this Form have been reviewed at the Medicare Visit appointment.**

Comments:
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____
Provider Printed Name

____
Provider Signature

____
Date