



Name: _____	DOB: ____/____/____
MR: _____	FIN: _____

ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT(HRA)

Dear _____,

Your Appointment for the Welcome to Medicare Visit **OR** Annual Wellness Visit is scheduled on _____ at _____.

There is **NO CO-PAY** for this visit, so it is free for you!

The goal of this visit is to provide time for you to discuss with our health care team, areas of your health that may put you at risk for problems and to help you and your provider better understand what screenings you should get in the future.

At your wellness visit, we will take a complete health history and provide several other services:

- Screenings to detect depression, risk for falling and other problems,
- A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity,
- A screening schedule for appropriate preventive services will be developed
- Risk factors and treatment options will be reviewed and recommended

This is **NOT** a “Problem Visit and **WILL NOT** include treatment or management of problems.

So that your provider has all necessary information, **please complete ALL of the enclosed forms and bring them with you to your visit.**

If you arrive at the office without these forms, your visit may need to be rescheduled.

Please make sure to be on time and call with more than 24 hours’ notice if you cannot make your appointment.

We look forward to seeing you soon!



Name: _____ DOB: ___/___/___

MR: _____ FIN: _____

ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT(HRA)

_____ Patient Consented to a Telehealth Visit Telehealth Visit scheduled: _____

AWV PERFORMED BY:	Name (Print):	Date:
	Signature:	

Please complete the entire questionnaire as thoroughly as possible so that your provider has a complete and up to date history. This confidential history will be part of your permanent medical record.

Please list any ADDITIONAL providers and suppliers of your medical care such as primary care physicians, specialty physicians, chiropractors, pharmacies, herbalists and therapists.

PROVIDER NAME	SPECIALTY

Have you changed your Pharmacy? If yes, Please add name and address below:

MEDICATIONS	
****You must bring all your medications with you to this visit**** <i>(including anything you take over the counter)</i>	

NUTRITION	
How many servings of fruits and vegetables do you have in a day	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
How many servings of meat, fish or other proteins do you have in a day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know



Name: _____ DOB: ____/____/____

MR: _____ FIN: _____

ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT(HRA)

How many servings of fiber or whole grains do you have in a day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
How many servings of fried or high-fats foods do you have in a day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
How many servings of sugar sweetened drinks do you have in a day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know

The following ADHOC Forms have been completed in the patients chart:

DEPRESSION SCREENING (PHQ9) Office Use Only
_____ Completed _____ Your Initials

FALL RISK SCREENING – Office Use Only
_____ Completed _____ Your Initials

GENERAL WELL-BEING					
In general, would you say your health is?	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Do you take all your medications as prescribed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Almost Never	<input type="checkbox"/> I don't take medication
In the last six months, how many times were you admitted to the hospital?	<input type="checkbox"/> 0	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5+	<input type="checkbox"/> I don't know
In the last six months, how many times have you been to the emergency room?	<input type="checkbox"/> 0	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5+	<input type="checkbox"/> I don't know

SOCIAL/EMOTIONAL SUPPORT				
How often do you get the social and emotional support you need?	<input type="checkbox"/> Always	<input type="checkbox"/> Usually	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely <input type="checkbox"/> Never
STRESS/ANGER				
How often is stress/anger a problem for you?	<input type="checkbox"/> Never, rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
How well do you handle the stress/anger in your life?	<input type="checkbox"/> I'm usually able to cope effectively	<input type="checkbox"/> At times I have problems coping	<input type="checkbox"/> I often have problems coping	



Name: _____ DOB: ____/____/____

MR: _____ FIN: _____

ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT(HRA)

PAIN/FATIGUE				
How often do you feel unusually tired?	<input type="checkbox"/> Never, rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
Do you have pain that interferes with performing desired activities?	<input type="checkbox"/> Never, rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always

SLEEP	
How many hours of sleep do you usually get?	<input type="checkbox"/> 0-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-10 <input type="checkbox"/> 10+ <input type="checkbox"/> I don't know
Do you snore or has anyone told you that you snore?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
In the past 7 days, how often have you felt sleepy during the daytime?	<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Almost never <input type="checkbox"/> Never <input type="checkbox"/> I don't know

FUNCTIONAL ABILITY ASSESSMENT

<i>Instrumental activities of daily living</i>	
Which of the following can you do on your own?	<input type="checkbox"/> Shop for groceries <input type="checkbox"/> Use the telephone <input type="checkbox"/> Housework <input type="checkbox"/> Handle finances <input type="checkbox"/> Drive/use public transportation <input type="checkbox"/> Make meals <input type="checkbox"/> Take medications <input type="checkbox"/> None
Which of the following can you do on without help?	<input type="checkbox"/> Bath <input type="checkbox"/> Walk <input type="checkbox"/> Dress <input type="checkbox"/> Eat <input type="checkbox"/> Transfer in/out of chair, etc <input type="checkbox"/> Use the restroom <input type="checkbox"/> None

URINARY INCONTINENCE ASSESSMENT (WOMEN ONLY)

During the last three months, have you leaked urine (even a small amount)? When:	You were performing some physical activity (coughing, sneezing, lifting or exercise)? <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO STOP)
During the last 3 months did you leak urine when: When: (check all that apply)	<input type="checkbox"/> You were performing some physical activity (coughing, sneezing, lifting or exercise)? <input type="checkbox"/> You had the urge or the feeling that you needed to empty your bladder? <input type="checkbox"/> Without physical activity and without a sense of urgency?
During the last three months, did you leak urine most often (check only one):	<input type="checkbox"/> When you were performing some physical activity, such as <u>coughing</u> , sneezing, lifting, or exercise? <input type="checkbox"/> When you had the urge or the feeling that you needed to empty your <u>bladder</u> , but you could not get to the toilet fast enough? <input type="checkbox"/> Without physical activity and without a sense of urgency? <input type="checkbox"/> About equally as often with physical activity as with a sense of urgency?



Name: _____ DOB: ____/____/____

MR: _____ FIN: _____

ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT(HRA)

AMBULATION STATUS	
How long can you walk or move around?	<input type="checkbox"/> 0-5 <input type="checkbox"/> 5-15 <input type="checkbox"/> 15-30 <input type="checkbox"/> More than 1 hour <input type="checkbox"/> I don't know
Do you feel unsteady when standing or walking?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> I don't know
Which of these assistive devices do you use?	<input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Crutches <input type="checkbox"/> Other <input type="checkbox"/> None
Do you feel dizzy when you get up from a bed or chair?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> I don't know
Are you afraid to leave the house alone due to dizziness or imbalance problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> I don't know

HEARING SCREENING	
Do you have a problem with hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Do you use hearing aids or other devices to help you hear?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Do you have a problem hearing the telephone?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Do you have trouble hearing the television or radio	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Do people complain that you turn the TV volume up too high?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Do many people you talk to seem to mumble (or not speak clearly)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Do you find yourself asking people to repeat themselves?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Do you have trouble hearing in a noisy background?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know

VISION SCREENING	
Do you have problems with your vision?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Do you wear contact lenses or eyeglasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes

HOME SAFETY	
What is your living situation	<input type="checkbox"/> Alone <input type="checkbox"/> With my spouse or other family with a friend or roommate <input type="checkbox"/> In nursing home or assisted living facility/home <input type="checkbox"/> I don't have a place to live <input type="checkbox"/> Other
Does your home have rugs in the hallways?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Does your home have grab bars in the bathroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Is there any clutter in your walking space at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Does your home have functioning smoke alarms?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Does your home have handrails on stairs and steps?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know

MEMORY LOSS	
Have you experienced any memory issues or problems with thinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
Do family members report that you have difficulty remembering things?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know



Name: _____ DOB: ____/____/____

MR: _____ FIN: _____

ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT(HRA)

SUN EXPOSURE

Do you use Sun protection when outdoors Yes No I don't know

ADVANCE CARE PLANNING

_____ Completed _____ Your Initials

ADVANCED CARE PLANNING: Your responses to the following 10 questions may help you to better understand your thoughts on quality of life when considering treatment options: Check the appropriate answer for each question.

Consider the following statements and how important Advanced care planning is for you.	Very important	Somewhat important	Not Very important
1. Be free of pain <i>Comments:</i>			
2. Able to physically care for myself <i>Comments:</i>			
3. Live at Home <i>Comments:</i>			
4. Able to be outside and not spend all day at home <i>Comments:</i>			
5. Able to talk and understand others <i>Comments:</i>			
6. Die naturally and not be keep alive by machines <i>Comments:</i>			
7. Be financially independent <i>Comments:</i>			
8. Ability to do the activities I most enjoy. <i>List of Activities:</i>			
9. Do you have an Advance Directive, Living Will or Power of Attorney for Health Care (POA), in the case that an injury or illness causes you to be unable to make healthcare decisions?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know		
10. Would you like further information regarding Advance Directives?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I already have one		



Name: _____ DOB: ____/____/____

MR: _____ FIN: _____

ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT(HRA)

PHYSICAL ACTIVITY

Number of days patient exercises	_____ days
Number of minutes patient exercises	_____ minutes
Intensity of exercise	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> _____

MOTOR VEHICLE SAFETY

Use of seatbelt while in the car	<input type="checkbox"/> Always <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Drinking and driving	<input type="checkbox"/> Occasionally <input type="checkbox"/> Never

OFFICIAL USE ONLY

HRA Reviewed by:	Clinician Name (Print)	Date:
	Clinician Signature:	