

Medicare Health Risk Assessment

Name: _____

DOB: _____

Demographics/Living Arrangements

1. Is there anyone else involved with your health care decisions?

Self Family Power of Attorney Public Fiduciary

Guardian Spouse/Partner Other

If yes, Name: _____ Phone Number: _____

2. Do you have any special language and/or cultural needs?

Yes No

If yes, what are they? _____

3. What is your current living arrangement? (Mark all that apply)

Alone With spouse/partner Family member/friend

Paid Caregiver Independent Living Facility / Senior Housing or apartment

Congregate or Assisted Living Nursing Home Facility

4. Are you a caregiver for someone else?

Yes No

If yes, who? _____

5. Do you have a caregiver who provides you with any assistance?

Yes No

If yes, what type of assistance? _____

6. Physical Characteristics:

Hearing: Good Fair Poor Good with Hearing Aid

Vision: Good Fair Poor Good with Glasses

7. Are you currently receiving any of the following services from an agency? (Check all that apply)

Visiting Nurse Social Worker Physical Therapy

Occupational Therapy Speech Therapy Home Health Aid

Adult Day Care Center Transportation Service Home Delivered Meds

Homemaker/Chore Service

15. Do you currently see 3 or more doctors on a regular basis?

Yes No

Please bring a list of doctors you see regularly with you to your next appointment with our office.

16. Are you seeing a specialist?

Yes No

If yes, for what? _____

17. Alcohol Use:

Yes No

How many drinks per day? _____ How many drinks per week? _____

18. How often do you use prescription medication other than exactly as prescribed to you?

Never Sometimes Often

How often do you use recreational or illegal drugs?

Never Sometimes Often

19. In the last 30 days have you used tobacco?

Smoked Yes No

Smokeless Yes No

If you've smoked or used smokeless tobacco recently, would you be interested in quitting tobacco within the next month?

Yes No

20. How often do you feel sad or depressed?

Never Sometimes Often Always

How often do you feel anxious or nervous?

Never Sometimes Often Always

21. Do you have a history of emotional or psychiatric problems or have you ever seen a mental health professional?

Yes No

22. In the past 7 days, how many days did you exercise, such as a brisk walk, for at least 20 minutes per day?

1 2 3 4 5 6+ I did not exercise

23. Do you, like many people, have problems with bladder control or getting to the bathroom on time?

Yes No

24. In the past 7 days, how much did pain interfere in your day-to-day activities?

Not at all A little bit Somewhat Quite a bit Very much

25. In the past year, have you had any of the following screening tests or vaccines?

	I've done this in the past year			Please help me schedule an appointment		
	<u>Date</u>					
Breast Cancer screening	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Colorectal cancer screening	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Cervical cancer screening (PAP)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Bone Mineral Density screening	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Flu vaccine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Pneumonia Vaccine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Shingles Vaccine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Eye Exam	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Dental Exam	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Activities/Safety

26. In the past year, have you fallen to the ground or floor?

None 1-2 times 4 times or more

27. Do you have any concerns about safety in your home?

Yes No

28. How much difficulty do you have doing the following activities?

Bathing:

- No difficulty Some Difficulty Cannot do at all

Using the toilet:

- No difficulty Some Difficulty Cannot do at all

Dressing:

- No difficulty Some Difficulty Cannot do at all

Eating:

- No difficulty Some Difficulty Cannot do at all

Getting in/out of bed or chairs:

- No difficulty Some Difficulty Cannot do at all

Walking:

- No difficulty Some Difficulty Cannot do at all

If you have difficulty with any items above, does someone help you with any of these tasks?

- Yes No

29. How much difficulty do you have doing the following activities?

Taking medications:

- No Difficulty Some Difficulty Cannot do at all

Managing money:

- No Difficulty Some Difficulty Cannot do at all

Preparing meals:

- No Difficulty Some Difficulty Cannot do at all

Shopping for groceries:

- No Difficulty Some Difficulty Cannot do at all

Doing routine household chores:

- No Difficulty Some Difficulty Cannot do at all

If you have difficulty with any of the items listed above, does someone help you with any of these tasks?

- Yes No