East Paris Internal Medicine Associates, P.C. 1000 EAST PARIS AVENUE, S.E., SUITE 260 , GRAND RAPIDS, MI. 49546

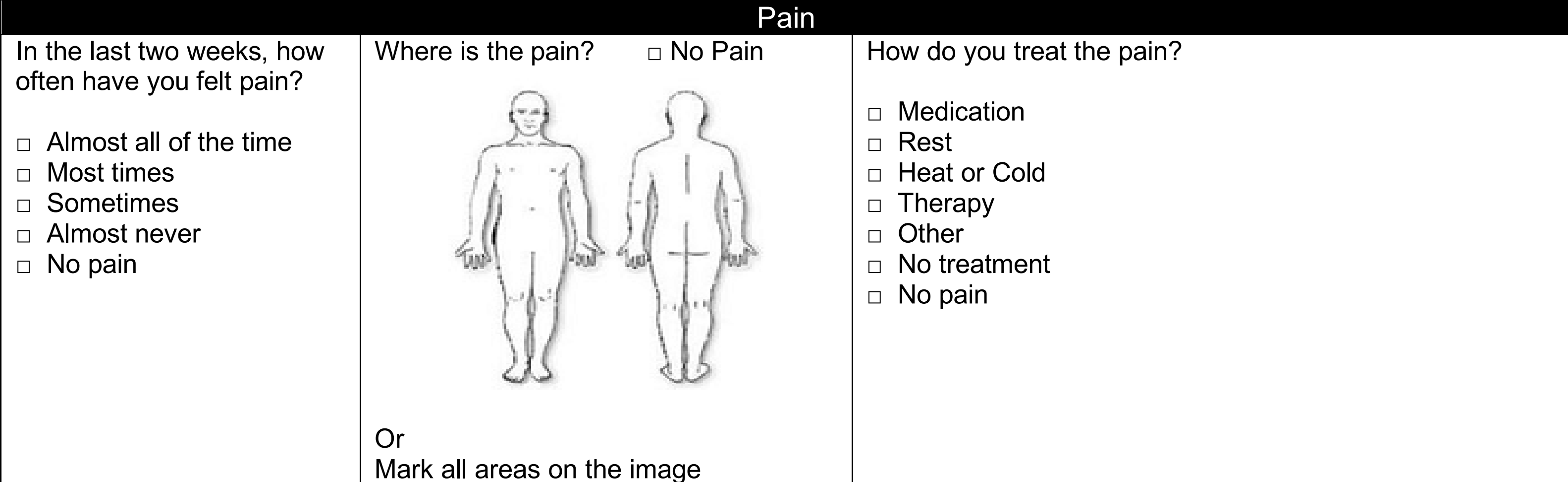
Medicare Annual Wellness Visit – Health Risk Assessment

Please Print Your Name and Date of Birth Name: DOB:

General Health	
How is your overall health?	□ Excellent □ Good □ Fair □ Poor □ I don't know
How many different prescriptions are you taking?	□ 0-3 □ 4-6 □ 7-10 □ 10+ □ I don't know
Do you take all your medications as prescribed?	□ Yes □ Sometimes □ Almost Never □ No □ I don't take medication
How many times in the last 6 months have you been to the Emergency Room?	□ 0 □ 1-2 □ 3-4 □ 5+ □ I don't know
How many times in the last 6 months were you admitted to the hospital?	□ 0 □ 1-2 □ 3-4 □ 5+ □ I don't know
Tobacco and Alcohol Use	
Do you use any tobacco products?	□ Yes □ No What form?
Are you interested in quitting tobacco?	□ Yes □ No □ I don't use tobacco
How many times in the past year have you had four or more alcoholic drinks in a day?	□ None □ 1-2 □ 3-4 □ 5+
Are you interested in receiving help for any other types of substance abuse?	□ Yes □ No □ I don't use other substance
Nutrition	
How many servings of fruits and vegetables do you usually eat each day?	□ None □ 1-2 □ 3-4 □ 5+ □ I don't know
How many servings of fiber or whole grain foods do you usually eat each day?	□ None □ 1-2 □ 3-4 □ 5+ □ I don't know
How many servings of meat, fish, or other protein do you usually eat each day?	□ None □ 1-2 □ 3-4 □ 5+ □ I don't know
How many servings of fried or high-fat foods do you usually eat each day?	□ None □ 1-2 □ 3-4 □ 5+ □ I don't know
How many servings of sugar-sweetened drinks do you usually have each day?	□ None □ 1-2 □ 3-4 □ 5+ □ I don't know
Physical Activity	
How many days a week do you exercise?	□ None □ 1-2 □ 3-4 □ 5+ □ I don't know
On the days you exercised, how long did you exercise?	□ 0-30 min □ 30 min – 1 hour □ More than 1 hour □ I don't know □ I don't exercise
How intense is your exercise?	□ Light (stretching/slow walking) □ Moderate (brisk walking) □ Heavy (jogging/swimming) □ Very heavy (running fast) □ I don't know □ I don't exercise
Sleep	
How many hours of sleep do you usually get?	□ 0-3 □ 4-6 □ 7-10 □ 10+ □ I don't know
Do you snore or has anyone told you that you snore?	□ Yes □ No □ I don't know
In the past 7 days, how often have you felt sleepy during the daytime?	□ Often □ Sometimes □ Almost Never □ Never □ I don't know
Functional Status	
Instrumental Activities of Daily Living	
Which of the following can you do without help?	□ Shopping □ Drive □ Laundry □ Make meals □ Housework □ Take medications □ Handle Finances □ None of these
Activities of Daily Living	
Which of the following can you do on your own without help?	□ Bathe □ Dress □ Eat □ Walk □ Transfer (in/ out of chairs) □ Use the restroom □ None of these
Ambulation Status	

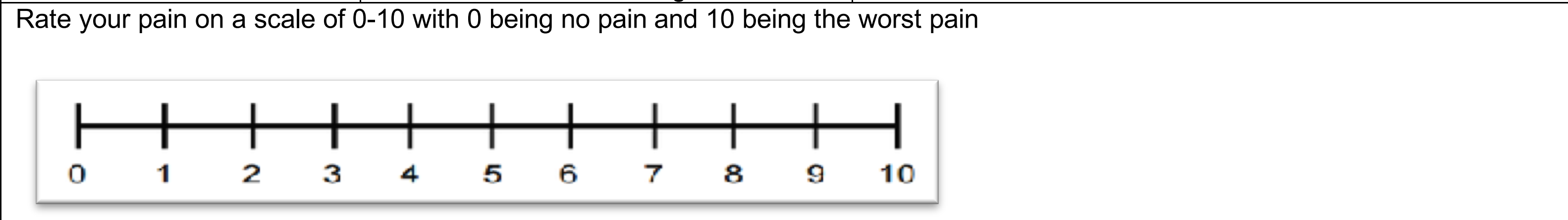
How long can you work or move around?	□ 0-5 min □ 5-15 min □ 15-30 min □ More than 1 hour □ I don't know
Which of these assistive devices do you use?	□ Cane □ Walker □Wheelchair □Crutches □Other □None
Do you have trouble with your balance?	□Yes □ No
Have you fallen in the last 12 months?	□Yes □No
Sensory Ability	
Do you have problems with vision?	□ Yes □ No □ I don't know
Do you use eyeglasses or contact lenses?	□ Yes □ No □ I don't know
Do you have problems with hearing?	□ Yes □ No □ I don't know
Do you use hearing aids or other devices to help you hear?	□ Yes □ No □ I don't know

Pain



In the last two weeks, how often have you felt pain?	Where is the pain? □ No Pain	How do you treat the pain?
□ Almost all of the time □ Most times □ Sometimes □ Almost never □ No pain	Or Mark all areas on the image	□ Medication □ Rest □ Heat or Cold □ Therapy □ Other □ No treatment □ No pain

Rate your pain on a scale of 0-10 with 0 being no pain and 10 being the worst pain



Home/ Safety

What is your living situation?	□ Alone □ With my spouse or other family □ With a friend or roommate □ In a nursing home or assisted living facility □ I don't have a place to live □ Other
Do you fasten your seatbelt in vehicles?	□ Yes □ No

Depression

In the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things.	□ Not at all □ Several Days □More than half the days □ Nearly every day
2. Feeling down, depressed, or hopeless.	□ Not at all □ Several Days □More than half the days □ Nearly every day

Social/ Emotional Support

Which of the following applies to you?	□ I have a supportive family □ I have supportive friends □ I participate in church, clubs, or other group activities □None
How often do you get out and meet with family and friends?	□ Often □ Sometimes □ Almost Never □ None

Advance Directives

Do you have a healthcare power of attorney or living will?	□ Yes □ No □ I don't know
Would you like more information?	□ Yes □ No

In this space, please indicate anything you would like us to know.

Medications (Prescriptions, Vitamins, and Over the Counter)			
Name	Dose	How Often?	What for?

Even though for most patients, we have your medications on file, it is very important that you fill them in above. We often find discrepancies and correct them during this visit.