Mountain Valleys HEALTH CENTERS

Medicare Annual Wellness Visit
Health Risk Assessment

Today's Date: _____

Patient Name: _____ DOB: _____

PERSONAL INFORMATION	
What is your primary language spoken at home?	English ☐ Spanish ☐ Other: ☐
How do you prefer we communicate?	Phone/Text: (#_____-_____-_____) E-mail:
Do you use a local pharmacy?	Yes ☐ No ☐ Name: Phone Number: (#_____-_____-_____)
GENERAL HEALTH	
How is your overall health?	Excellent ☐ Good ☐ Fair ☐ Poor ☐
How confident are you that you can manage most of your health problems?	Confident ☐ Somewhat ☐ Not very confident ☐ Don't have any health concerns ☐
What are your biggest concerns about managing your health? ***Check all that apply***	☐ None ☐ I live in an unsafe environment ☐ Transportation to appointments ☐ Financial difficulty in paying for services/medicines ☐ I have difficulty taking or remembering my medicines ☐ Difficult reading or understanding instructions ☐ I am lonely or don't have a lot of support at home ☐ I fall a lot at home
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 have you been admitted to the hospital?	0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know ☐
Please list any new healthcare providers you have seen since your last visit with us.	
How many different prescriptions are you taking?	0-3 ☐ 4-6 ☐ 7-10 ☐ 10+ ☐ I don't know ☐
Please list any new medicines you have started since your last visit with us.	
Have you had any problems with your vision?	Yes ☐ No ☐
Have you had any problems with your hearing?	Yes ☐ No ☐
Have you had any problems with your teeth or dentures?	Yes ☐ No ☐

Do you or your family members have any concerns about your memory?	Yes ☐ No ☐
Please list any updates to your Family Medical History (family conditions that your doctor may not know about):	
TOBACCO AND ALCOHOL USE	
Do you use any tobacco products? (Cigarettes, chew, snuff, pipes, cigars)	Yes ☐ No ☐
If so, are you interested in quitting tobacco?	Yes ☐ No ☐ I don't use tobacco ☐
How many times in the past year have you had 4 or more drinks in a day?	Daily-or-almost-daily ☐ Weekly ☐ Monthly ☐ Once-or-twice ☐ Never ☐
Do you use any illegal drugs or take any prescription medications that have not been prescribed to you?	Yes (please describe): No ☐
NUTRITION	
Do you follow any special diet? (low sodium/cholesterol/fat?)	Yes ☐ No ☐
Do you use any dietary supplements, including meal replacement drinks?	Yes ☐ No ☐
In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?	0 ☐ 1-2 ☐ 3-4 ☐ I don't know ☐
PHYSICAL ACTIVITY	
How many days a week do you exercise?	0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know ☐
How intense is your exercise?	Light ☐ Moderate ☐ Heavy ☐ Very Heavy ☐ 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 day?	Often ☐ Sometimes ☐ Almost Never ☐ Never ☐
Have you ever been diagnosed with Sleep Apnea or other sleep disorders?	Yes ☐ No ☐ I don't know ☐
Are you currently using or have you used C-PAP/Bi-PAP?	Yes ☐ No ☐
DEPRESSION PHQ-2	

In the past 2 weeks, how often have you been bothered by the following problems:	Not at all:	Several Days:	More than half of those days:	Nearly every day:
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3

Total Score: _____

FUNCTIONAL STATUS ASSESSMENT

Activities of daily living (ADL's) - Please check those that apply.

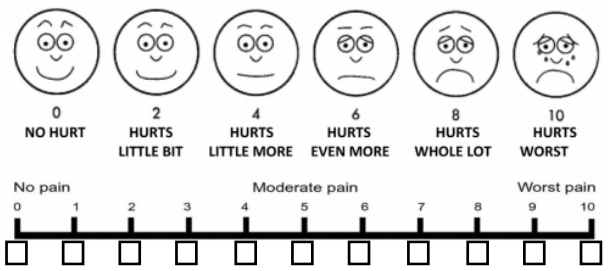
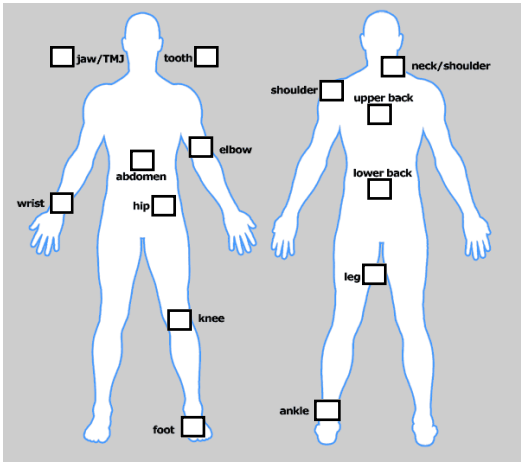
Which of the following can you do on your own without help?	Bathe ☐ Dress ☐ Eat ☐ Walk ☐ Use the restroom ☐ Transfer in/out of chairs, etc. ☐ None ☐
Does someone help you at home? If yes, please provide Caregiver Name:	Yes ☐ No ☐ Spouse ☐ Children ☐ Other: Aide/Caregiver #:
Many people experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experienced leaking of urine?	Yes ☐ When cough/sneeze ☐ No ☐ I don't know ☐

Instrumental activities of daily living (IADL's) - Please check those that apply.

Which of the following can you do on your own without help?	☐ Shop for groceries ☐ Housework ☐ Drive/Use public transportation ☐ Make meals ☐ None ☐ Use the telephone ☐ Handle finances ☐ Take Medications

HOME/SAFETY

What is your housing situation like? ***Check all that apply***	☐ Live with one or more children or dependent ☐ Live in an assisted living facility ☐ Live in a nursing facility ☐ Live alone ☐ I have housing today, but I am worried about losing housing in the future ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

Do you have a problem with any of the following at your home? ***Check all that apply***	☐ Bug infestation ☐ Mold ☐ Lead paint or pipes ☐ Inadequate heat ☐ Oven or stove not working ☐ No or not working smoke detectors ☐ Water leaks ☐ None of the above
Do you feel safe in your home?	Yes ☐ No ☐
Does your home have working smoke alarms?	Yes ☐ No ☐ I don't know ☐
Do you have throw rugs on your floor(s)?	Yes ☐ No ☐
Do you have handrails in the bathroom?	Yes ☐ No ☐
Do you have proper lighting in your home?	Yes ☐ No ☐
Do you have handrails for the stairs?	Yes ☐ No ☐ I don't have stairs ☐
Do you fasten your seatbelt in vehicles?	Yes ☐ No ☐ I don't ride in vehicles ☐
PAIN ASSESSMENT	
In the past 2 weeks, how often have you felt pain?	Almost all of the time ☐ Most times ☐ Sometimes ☐ Almost never ☐ Never ☐
Where is the pain? ***Mark all areas in which pain is present.*** Rate your pain on the following scale:  	
How do you treat the pain?	Medication ☐ Rest ☐ Heat/Cold ☐ Therapy ☐ I don't treat my pain ☐
RISK FOR FALLING	
Which of these assistive devices do you use? ***Please circle all that apply***	Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Other ☐ None ☐
Do you have trouble with your balance?	Yes ☐ No ☐
Have you fallen 2 or more times or have had a fall with injury in the past year?	Yes ☐ No ☐
Are you afraid of falling?	Yes ☐ No ☐
Do you have any amputations?	Yes ☐ No ☐ If yes, where?:
SENSORY ABILITY *(please circle all that apply)*	

Do you have problems with vision? Eye Doctor name:	Yes ☐ No ☐ If yes, please identify: Legally blind ☐ Cataracts ☐ Diabetic Retinopathy ☐ Other:
Do you use eyeglasses or contacts?	Yes ☐ No ☐
Do you have problems with your hearing? ENT/Hearing Specialist name:	Yes ☐ No ☐ If yes, please identify: Partial hearing loss ☐ Deaf ☐ TTY ☐ Other:
Do you use hearing aids or other devices to help you hear?	Yes ☐ No ☐
SOCIAL/EMOTIONAL SUPPORT *(please circle all that apply)*	
Which of the following applies to you? ***Please check all that apply***	☐ I have a supportive family ☐ I have supportive friends ☐ I participate in church, clubs, or other groups ☐ None
How often do you get out and meet with family and friends?	Often ☐ Sometimes ☐ Almost Never ☐ Never ☐
Describe your current living situation.	Alone ☐ Spouse ☐ Children ☐ Homeless ☐ Assisted Living Facility ☐ Don't have a stable home ☐
ADVANCE DIRECTIVES	
Does your family or friends know what you want in an emergency situation or if you could not speak for yourself? ***Check all that apply*** *If you have any of the following, it would be helpful to have a copy provided to us for your medical record.*	☐ No ☐ Yes, and I have completed: ☐ A living will (Advance Directive) ☐ Power of Attorney for Health Care ☐ POLST (in some states known as: POST, MOST, MOLST, TPOPP) ☐ Five wishes
Would you like more information?	Yes ☐ No ☐ Unsure ☐

ALLERGIES – Drugs, Food, Environment		

MEDICATIONS – Prescriptions, Vitamins, Over-the-Counter			
Name	Dose	Date Started	Condition Treating

SELF & FAMILY HISTORY *(mark the columns that apply)*						
	None	**Self**	**Parent**	**Brother**	**Sister**	**Child**
Congestive Heart Failure						
Diabetes						
COPD (Chronic Lung Disease) or Asthma						
Hypertension						
Stroke						
Kidney Disease						
Obesity						
Liver Disease						
Bipolar Disorder or Schizophrenia						
Dementia						
Cancer						
Depression						

OTHER PHYSICIANS/ HEALTHCARE PROVIDERS		
Specialty	**Physician Name**	**Last Seen**
Cardiologist		
Dermatologist		
Ear, Nose, & Throat (ENT)		
Endocrinologist		
Eye/Optometry/Ophthalmologist		
Gastroenterologist		
Gynecologist		
Hematologist/Oncologist		
Nephrologist		
Neurologist		
Orthopedist		
Podiatrist		
Pulmonologist		
Psychiatrist/Psychologist		
Rheumatologist		
Urologist		
Other:		

*This additional PHQ-9 screening should only be provided to the patient to complete, or be conducted through patient interview by a clinical staff member, **IF** the PHQ-2 was positive.

DEPRESSION PHQ-9				
In the past 2 weeks, how often have you been bothered by the following problems:	**Not at all:**	**Several Days:**	**More than half of those days:**	**Nearly every day:**
Little interest or pleasure in doing things	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Feeling down, depressed, or hopeless	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Trouble falling or staying asleep or sleeping too much	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Feeling tired or having little energy	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Poor appetite or overeating	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Feeling bad about yourself, or that you're a failure, or have let yourself or family down	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Trouble concentrating on things, such as reading the newspaper or watching television	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you've been moving around a lot more than usual	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Thoughts that you would be better off dead, or of hurting yourself	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Total Score:				
If you checked off any of the problems in this section, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all ☐	Somewhat ☐	Very difficult ☐	Extremely difficult ☐