Enclosure 1b

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

8. Do you use any of the following special equipment?

☐Hospital Bed ☐Hoyer Lift ☐Grab bars
☐Bedside Commode ☐Wheelchair ☐Cane
☐Walker ☐Other

9. Do you receive any of the following special treatments?

☐Tube feeding ☐Tracheostomy Care ☐Ostomy Care
☐Wound Care ☐Chemotherapy ☐Oxygen
☐CPAP ☐Insulin Pump ☐Nebulizer
☐Dialysis

Advance Care Planning

10. Have you completed a Living Will, Advance Directives, or other Health Care Wishes document?

☐Yes ☐No ☐I don't know

If yes, please bring a copy with you to your next appointment with our office

Health & Well Being

11. In general, how do you rate your health overall?

☐Excellent ☐Good ☐Fair ☐Poor

12. How many medications (prescription and over-the-counter) do you take on a regular basis?

☐None ☐1-4 ☐5-9 ☐10+

Please bring a list of prescription and over-the-counter medications with you on your next

13. Without wanting to, have you lost 10 pounds or more in the past 2 months?

☐Yes ☐No

14. In the past 6 months, how many times have you...

	None	1	2	3	4-5	6+
Visited a doctor's office or clinic?	☐	☐	☐	☐	☐	☐
Gone to an emergency room or Urgent Care Center?	☐	☐	☐	☐	☐	☐
Stayed overnight as a patient in a hospital?	☐	☐	☐	☐	☐	☐

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 Date			Please help me schedule an appointment		
Breast Cancer screening	☐Yes	☐No	☐N/A	☐Yes	☐No	☐N/A
Colorectal cancer screening	☐Yes	☐No	☐N/A	☐ Yes	☐No	☐N/A
Cervical cancer screening (PAP)	☐Yes	☐No	☐N/A	☐Yes	☐No	☐N/A
Bone Mineral Density screening	☐Yes	☐No	☐N/A	☐Yes	☐No	☐N/A
Flu vaccine	☐Yes	☐No	☐N/A	☐Yes	☐No	☐N/A
Pneumonia Vaccine	☐Yes	☐No	☐N/A	☐Yes	☐No	☐N/A
Shingles Vaccine	☐Yes	☐No	☐N/A	☐Yes	☐No	☐N/A
Eye Exam	☐Yes	☐No	☐N/A	☐Yes	☐No	☐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