JAY MEDICAL CLINIC

Medicare Annual Wellness Visit

HEALTH RISK ASSESSMENT

Patient Name: _____ Date of Birth:_____ Date: _____

GENERAL HEALTH	
How is your overall health?	☐ Excellent ☐ Good ☐ Fair ☐ Poor
How many different prescriptions are you taking	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+
Do you take all of your medications as prescribed?	☐ Yes ☐ No ☐ Sometimes ☐ Almost Never ☐ I don't take medication
How is the health of your mouth and teeth?	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know
Do you have a dentist that you visit regularly?	☐ Yes ☐ No
How many times in the last six months have you been to the emergency room?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+
How many times in the last six months were you admitted to the hospital?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+
TOBACCO AND ALCOHOL USE	
Do you use any tobacco products?	☐ Yes ☐ No
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 type of substance abuse?	☐ Yes ☐ No ☐ I don't use other substances
NUTRITION	
How many servings of fruit 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
PHYSICAL ACTIVITY	
How many days a week do you exercise?	☐ None ☐ 1-2 ☐ 3-4 ☐ 5+
On the days that you exercised, how long did you exercise?	☐ 0-30 min. ☐ 30 min to 1 hr ☐ More than 1 hr ☐ 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 exercise
SLEEP	
How many hours of sleep do you usually get?	☐ 0-3 ☐ 4-6 ☐ 7-10 ☐ 10+
Do you snore or has anyone told you that you snore?	☐ Yes ☐ No ☐ I don't know
In the past seven days, how often have you felt sleepy during the daytime?	☐ Often ☐ Sometimes ☐ Almost Never ☐ Never ☐ I don't know

Advance Directives	
Do you have a health care power of attorney or a living will?	☐ Yes ☐ No
Would you like more information?	☐ Yes ☐ No

JAY MEDICAL CLINIC

Medicare Annual Wellness Visit
HEALTH RISK ASSESSMENT

FUNCTIONAL STATUS ASSESSMENT

Instrumental activities of daily living

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

Activities of Daily Living

Which of the following can you do on your own without help?	☐ Bath ☐ Dress ☐ Eat ☐ Use restroom ☐ Walk ☐ Transfer (in/out of chairs, etc) ☐ None
Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?	☐ Yes ☐ No

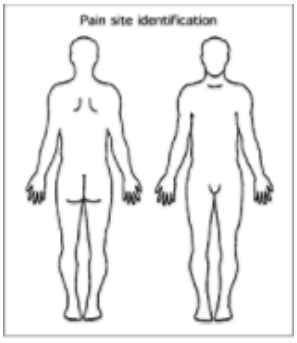
Ambulation status

How long can you walk or move around?	☐ 0-5 min. ☐ 5-15 min. ☐ 15-30 min. ☐ More than 1 hr ☐ 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 six months?	☐ Yes ☐ No

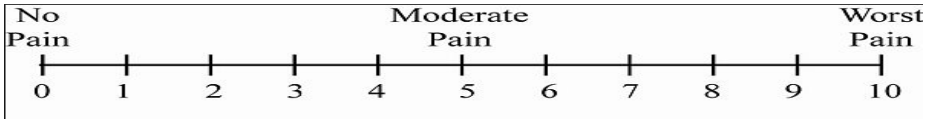
Sensory Ability

Do you have problems with vision?	☐ Yes ☐ No ☐ I don't know
Do you have 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 devises to help you hear?	☐ Yes ☐ No ☐ I don't know

PAIN ASSESSMENT

In the past two weeks, how often have you felt pain? ☐ Almost all the time ☐ Most times ☐ Sometimes ☐ Almost Never ☐ No Pain	Where is the pain? ☐ No Pain **OR** Mark all areas indicated 	How do you treat pain? ☐ Medication ☐ Rest ☐ Heat or Cold ☐ Therapy ☐ Other ☐ No treatment plan ☐ No Pain

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



JAY MEDICAL CLINIC

Medicare Annual Wellness Visit
HEALTH RISK ASSESSMENT

HOME/SAFETY		
What is your living situation?	☐ Alone ☐ With a friend or roommate ☐ I don't have a place to live	☐ With my spouse or other family member ☐ In a nursing home or assisted living ☐ Other
Does your home have working smoke alarms?	☐ Yes ☐ No	☐ I don't know
Do you fasten your seatbelt in vehicles?	☐ Yes ☐ No	

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

OFFICIAL USE ONLY	
Patient Signature:	Date Completed:
Clinician Signature:	Date Completed:

☐ ***The AWV and HRA were completed today. This included the following topics: General health, Tobacco/Alcohol use, Nutrition, Physical activity, Sleep, Advance Directive and Living Will information offered to patient, ADLS, Fall risk assessment, Pain risk assessment, Home safety and Depression-PHQ-9 completed and reviewed.***