Print Name: _____

Date of Birth: _____

Date: _____

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Medicare Health Risk Assessment

General Well-Being
In general, would you say your health is? (*Check one*)
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Have you noticed any changes with your memory lately?
☐ Yes ☐ No

How confident are you that you can control and manage most of your health problems? (*Check one*)
☐ Very confident ☐ Somewhat confident
☐ Not very confident ☐ I do not have any health problems

During the past 4 weeks, how much bodily pain have you generally had? (*Check one*)
☐ No pain ☐ Very mild pain ☐ Mild pain
☐ Moderate pain ☐ Severe pain

How often do you have trouble taking medicines the way you have been told to take them? (*Check one*)
☐ I do not take medicine.
☐ I always take them as prescribed.
☐ Sometimes I take them as prescribed.
☐ I seldom take them as prescribed.

How many hours of sleep do you usually get each night?
_____ hours.

General Life Satisfaction
In general, how satisfied are you with your life? (*Check one*)
☐Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

Opioid Screening
Are you currently prescribed a prescription narcotic or opioid medication (e.g., Vicodin, oxycodone, etc.)? ☐ Yes ☐ No

If yes, what is your current pain level, (1-10)? _____

How often do you use non-narcotic or non-opioid pain management options? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never
Are you currently seeing or have seen in the past a pain specialist? ☐ Yes ☐ No

Social/Emotional Support
Have your feelings caused you distress or interfered with your ability to interact socially with friends? ☐ Yes ☐ No

How often is stress a problem for you? (*Check one*)
☐ Never/rarely ☐ Sometimes ☐ Often ☐ Always

How well do you handle stress in your life? (*Check one*)
☐ I'm usually able to cope effectively.
☐ At times I have problems coping.
☐ I often have problems coping.

How often do you get the social and emotional support you need? (*Check one*)
☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Nutrition
On a typical day, how many servings of fruits and/or vegetables do you eat?
1 serving= 1 cup of fresh vegetables, ½ cup of cooked vegetables or 1 medium piece of fruit.
_____Servings per day

On a typical day, how many servings of high fiber or whole grain foods do you eat?
1 serving= 1 slice of 100% whole wheat bread, or ½ cup of cooked brown rice or whole wheat pasta.
_____Servings per day

On a typical day, how many servings of fried or high-fat foods do you eat? _____Servings per day

Physical Activity/Exercise
How intense is your typical exercise? (*Check one*)
☐ Light (like stretching or slow walking)
☐ Moderate (like brisk walking)
☐ Heavy (like jogging or swimming)
☐ Very heavy (like fast running or stair climbing)
☐ I am currently not exercising

Family History
Have there been any significant illnesses in your family members over the past year? ☐ Yes ☐ No
If yes, please list who and what illness: _____

Activities of Daily Living

Can you get to places out of walking distance without help?	☐ Yes ☐ No
Can you go shopping for groceries or clothes without someone's help?	☐ Yes ☐ No
Can you prepare your own meals?	☐ Yes ☐ No
Can you do housework without help?	☐ Yes ☐ No
Do you need help bathing, eating, dressing, or going to the bathroom?	☐ Yes ☐ No
Do you need help with managing your finances?	☐ Yes ☐ No
Does your home have rugs in hallways, poor lighting, or slippery surfaces in bathroom?	☐ Yes ☐ No
In your home do you have railings or stairs or grab bars in the bathroom?	☐ Yes ☐ No
Do you have trouble hearing the television or radio?	☐ Yes ☐ No
Do you struggle to hear or understand conversations?	☐ Yes ☐ No
Are you struggling at all with your vision or ability to see clearly enough to drive or watch TV?	☐ Yes ☐ No

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Patient Name (Please Print):_____**Date of Birth:** _____

To ensure accuracy in your personal medical records, please list all providers of your healthcare team as well as medical suppliers for any durable medical equipment you have.

If you are not seeing any specialists, please check this box. ☐

Specialist Name:	**Date last seen:**
Medical Supplier:	**Durable Medical Equipment (DME):**