# MEDICARE HEALTH RISK & SCREENING TOOL

For Medicare to pay for a wellness visit, the patient MUST complete a Health Risk Assessment Form. Please complete the form. If you need our assistance, please ask and our staff will be happy to help you.

**Patient Name:**______________________________ **Birth Date:** ______________

**EXERCISE:** Type: ______________________________

How Often?______________________ How long each time? ______________

**DIET:** On average per day, how many servings of the following do you eat?

Fruits: __________ Dairy: __________ Vegetables: __________ Fiber: __________

In an average week, how many servings of the following do you eat?

*Red Meat (beef/pork)* ______________ servings per week
*Chicken* ______________ servings per week
*Fish* ______________ servings per week
*Fried Foods* ______________ servings per week
*Fast Food* ______________ servings per week
*Restaurant* ______________ servings per week

Do you take supplements?

*Calcium* ______ Yes________No______________How many units/milligrams
*Vitamin D* ______ Yes________No______________How many units/milligrams
*Multi-Vitamin* ______ Yes________No___________ How many units/milligrams
*Other (Please list)* ______________________________

**CHRONIC OPIOD SCREEN:** Are you on chronic opioid therapy? ______Yes ____No ___________

**ALCOHOL:** How many drinks per day?______________OR per week? ______________

Have you drunk more heavily in the past?________________Yes ____________No

**TOBACCO:** Do you currently smoke?______________Yes______________No If yes, how much? ______________

Have you smoked in the past?____________Yes__________No If yes, when did you quit? ______________

Have you ever chewed tobacco or used snuff?______________Yes__________No If yes, when?____________how much? __________

**AUTOMOBILE:** Do you drive? ______Yes ______No

Do you wear a seat belt? ______Yes ______No

Do you drive after drinking or ride with a driver who has been drinking?__________________Yes ______No

**SUN:**

Do you wear sunscreen? ______ Always ______ Sometimes ______ NevER

**SELF CARE:** **Do you have problems with your vision?** ________**Yes** ________**No**

Last eye doctor appointment______________________________________________How often? ________________________

Last dental appointment ________________________________________________________________________________

Do you have trouble hearing the television or radio when others do not? _____Yes ____No

Do you have to strain or struggle to hear or understand conversation? _____ Yes ____No

In the last month, have you felt down, depressed, and hopeless? _____ Yes ____ No

In the last month, have you lost interest or pleasure in doing things you usually like to do? _____ Yes _____ No

In the past year have you had 2 or more falls? ____ Yes _____No

In the past year have you fallen which resulted in an injury? ____ Yes _____No

Do you have problems doing things with your hands such as buttoning, cooking, cleaning?_________________________Yes_________No

Are you having problems with your memory?_________________Yes ______No

Do you have a living will?______________Yes ______No

Have you named a Medical Power of Attorney?_________Yes ______No

Have you discussed your wished for what happens to you if you can't communicate? (I.e. had a stroke or been in an accident?) ______Yes ______No

**SOCIAL:** Do you feel safe where you live? ______Yes ______No

Do you feel you can count on family or friends to help you? ______Yes ______No

**SLEEP:** Do you feel you have problems with sleep, snoring or day time sleepiness? ___ yes ___ no

Would you like to speak with us about this? ___ yes ___ no

**LIST OTHER PROVIDERS RENDERING YOU CARE:** ______________________________________________________________

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**COGNITIVE SCREEN:** Draw a clock face, including all the numbers. Place the hands on the clock to read 4:10.

**PATIENT TO LEAVE THE BELOW BLANK. TO BE COMPLETED BY THE PROVIDER. RECALL 3 UNRELATED ITEMS**

1. ______________________________________________________________
2. ______________________________________________________________
3. ______________________________________________________________

**VISION SCREENING:**

| | RIGHT EYE | LEFT EYE | BOTH EYES |
|---|---|---|---|
| WITHOUT CORRECTION | | | |
| WITH CORRECTION | | | |

**PROVIDER SIGNATURE:**______________________________________________________________DATE: ___________________