First Choice Family Practice
Best Care + Best Health

Medicare Annual Wellness Visit
HEALTH RISK ASSESSMENT

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

GENERAL HEALTH					
1. How is your overall health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ I don't know
2. How many different prescriptions are you taking?	☐ 0-3	☐ 4-6	☐ 7-10	☐ 10+	☐ I don't know
3. Do you take all of your mediations as prescribed?	☐ Yes	☐ Sometimes	☐ Almost never		
	☐ No	☐ I don't take medication			
4. How is the health of your mouth and teeth?	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ I don't know
5. Do you have a dentist that you visit regularly?	☐ Yes	☐ No	☐ I don't know		
6. How many times in the last six months have you been to the emergency room?	☐ 0	☐ 1-2	☐ 3-4	☐ 5+	☐ I don't know
7. How many times in the last six months were you admitted to the hospital?	☐ 0	☐ 1-2	☐ 3-4	☐ 5+	☐ I don't know

TOBACCO AND ALCOHOL USE, HCPCS CODES 99406, G0442				
8. Do you use any tobacco products?	☐ Yes	☐ No		
9. Are you interested in quitting tobacco?	☐ Yes	☐ No	☐ I don't use tobacco	
10. How many times in the past year have you had four or more alcoholic drinks in a day?	☐ None	☐ 1-2	☐ 3-4	☐ 5+
11. Are you interested in receiving help for any other type of substance abuse?	☐ Yes	☐ No		
	☐ I don't use other substances			

NUTRITION					
12. How many servings of fruits and vegetables do you usually eat each day?	☐ None	☐ 1-2	☐ 3-4	☐ 5+	☐ I don't know
13. 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
14. 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
15. 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
16. How many servings of sugar-sweetened drinks do you usually have each day?	☐ None	☐ 1-2	☐ 3-4	☐ 5+	☐ I don't know

PHYSICAL ACTIVITY					
17. How many days a week do you exercise?	☐ None	☐ 1-2	☐ 3-4	☐ 5+	☐ I don't know
18. On the days that you exercised, how long did you exercise?	☐ 0-30 min.	☐ 30 min. to 1 hour	☐ More than 1 hour		
	☐ I don't know		☐ I don't exercise		
19. How intense is your exercise?	☐ Light (stretching, slow walking)		☐ Moderate (brisk walking)		
	☐ Heavy (jogging, swimming)		☐ Very heavy (running fast)		
	☐ I don't know		☐ I don't exercise		

SLEEP					
20. How many hours of sleep do you usually get?	☐ 0-3	☐ 4-6	☐ 7-10	☐ 10+	☐ I don't know
21. Do you snore or has anyone told you that you snore?	☐ Yes	☐ No	☐ I don't know		
22. In the past seven days, how often have you felt sleepy during the daytime?	☐ Often	☐ Sometimes	☐ Almost never		
	☐ Never	☐ I don't know			

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FUNCTIONAL STATUS ASSESSMENT, CPT II CODE 1170F

Instrumental activities of daily living

23. 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

24. Which of the following can you do on your own without help?

☐ Bath ☐ Dress ☐ Eat
☐ Walk ☐ Transfer (in/out of chairs, etc.)
☐ Use the restroom ☐ None

25. Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?

☐ Yes ☐ No ☐ I don't know

Ambulation status

26. How long can you walk or move around?

☐ 0-5 min. ☐ 5-15 min. ☐ 15-30 min.
☐ More than 1 hour ☐ I don't know

27. Which of these assistive devices do you use?

☐ Cane ☐ Walker ☐ Wheelchair
☐ Crutches ☐ Other ☐ None

28. Do you have trouble with your balance? ☐ Yes ☐ No

29. Have you fallen in the last six months? ☐ Yes ☐ No

Sensory ability

30. Do you have problems with vision? ☐ Yes ☐ No ☐ I don't know

31. Do you use eyeglasses or contact lenses? ☐ Yes ☐ No ☐ I don't know

32. Do you have problems with hearing? ☐ Yes ☐ No ☐ I don't know

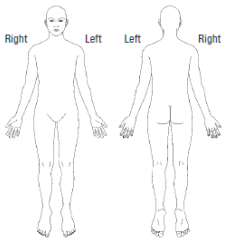
33. Do you use hearing aids or other devices to help you hear? ☐ Yes ☐ No ☐ I don't know

PAIN ASSESSMENT, CPT II CODES 1125F, 1126F

34. In the past two weeks, how often have you felt pain?
☐ Almost all of the time
☐ Most times
☐ Sometimes
☐ Almost never
☐ No pain

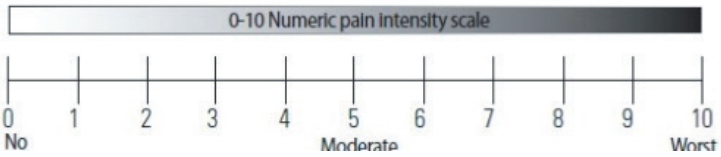
35. Where is the pain?

☐ No pain
or
Mark all areas indicated on the image



36. How do you treat the pain?
☐ Medication
☐ Rest
☐ Heat or cold
☐ Therapy
☐ Other
☐ No treatment plan
☐ No pain

37. Rate your pain on a scale of 0-10 with 0 being no pain and 10 being the worst pain:
Circle the number on the scale



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

DEPRESSION – (PHQ-9), HCPCS CODE G0444				
In the last two weeks, how often have you been bothered by any of the following problems?				
41. Little interest or pleasure in doing things.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
42. Feeling down, depressed, or hopeless.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
43. Trouble falling or staying asleep or sleeping too much.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
44. Feeling tired or having little energy.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
45. Poor appetite or overeating.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
46. 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 ☐ I don't know
47. 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 ☐ I don't know
48. 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.	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day ☐ I don't know
49. 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 ☐ I don't know
50. If you checked off any 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

SOCIAL/EMOTIONAL SUPPORT				
51. Which of the following applies to you?	☐ I have a supportive family	☐ I have supportive friends		
	☐ I participate in church, clubs, or other group activities	☐ None		
52. How often do you get out and meet with family and friends?	☐ Often	☐ Sometimes	☐ Almost never	☐ None

ADVANCE DIRECTIVES, CPT II CODES 1157F, 1158F; HCPCS CODE S0257			
53. Do you have a health care power of attorney or a living will?	☐ Yes	☐ No	☐ I don't know
54. Would you like more information?	☐ Yes	☐ No	

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MEDICATIONS (PRESCRIPTIONS, VITAMINS, OVER THE COUNTER)
CPT II CODE 1159F, 1160F

Name	Dose	Date started	Condition treating

SELF AND 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					

OTHER PHYSICIANS OR HEALTH CARE PROVIDERS

Specialty	Physician name	Date last seen
Cardiologist		
Pulmonologist		
Eye doctor		
Endocrinologist		
Physical therapist		
Gynecologist		
Dermatologist		
Ear, nose, and throat		

HEALTH RISK ASSESSMENT

ALLERGIES (DRUG, FOOD, ENVIRONMENT)	

OFFICIAL USE ONLY	
Reviewed by **Clinician name:**	
Clinician signature:	**Date:**