MEDICARE HEALTH RISK ASSESSMENT

Patient Label
DATE:
MRN:
NAME:
DATE OF BIRTH:

Thank you for choosing us to assist you in improving your health. If you feel that your physical or mental health is not as good as it was last year, let's talk about how we can help!

How would you rate your health in general?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

Climbing several flights of stairs.

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

During the past 4 weeks, have you had any of the following problems with your regular daily activities as a result of your physical or emotional health?

	None of the time	**Some of the time**	**Most of the time**	**All of the time**
Accomplished less than you would like as a result of your physical health?	☐	☐	☐	☐
Your activities were limited as a result of your physical health?	☐	☐	☐	☐
Had pain interfere with your normal work (including work outside and housework)?	☐	☐	☐	☐
Had a lack of energy?	☐	☐	☐	☐
Have you been unable to relax?	☐	☐	☐	☐
Have you felt sad and blue?	☐	☐	☐	☐
Didn't do work or other activities as carefully as usual as a result of any emotional problems?	☐	☐	☐	☐
Accomplished less than you would like as a result of your emotional problems?	☐	☐	☐	☐
Had physical or emotional problems interfere with your social activities (like visiting with friends, relatives, etc.)?	☐	☐	☐	☐
Have you felt lonely?	☐	☐	☐	☐
Do you use tobacco products?	☐	☐	☐	☐
Do you drink more than 1 glass of alcohol per day?	☐	☐	☐	☐

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	None of the time	Some of the time	Most of the time	All of the time
Do you exercise at least 20 minutes a day for 3 or more days a week?	☐	☐	☐	☐
Do you take your medicines as you have been advised to take them?	☐	☐	☐	☐
Do you follow the advice of your provider regarding routine tests or shots you may need to keep you healthy?	☐	☐	☐	☐
Does your needed housework get done?	☐	☐	☐	☐
Can you take care of your personal care needs, such as eating, bathing, dressing or getting around the house without the help of another person?	☐	☐	☐	☐
Can you get to places which are not within walking distance without help? (For example, traveling alone on buses, taxis, or driving your own car?)	☐	☐	☐	☐
Can you go shopping for clothes or groceries without help?	☐	☐	☐	☐
Do you fasten your seatbelt in the car?	☐	☐	☐	☐

	YES	NO
Have you fallen 2 or more times in the past 12 months?	☐	☐
Have you been afraid of falling due to balance, walking problems or your home environment?	☐	☐
Have you or others noticed a loss in your hearing?	☐	☐
Do you have concerns about your sexual health?	☐	☐
Have you experienced urinary incontinence (leaking of urine) in the past 6 months?	☐	☐
Do you have problems with your teeth or dentures?	☐	☐
Do you have an advance directive or living will? (If so, please provide us with a copy)	☐	☐
Do you have a durable power of attorney for health care? (If so, please provide us with a copy)	☐	☐

Please print the following:

Full name:

Today's date:

Current time:

City and state you are in right now:

Patient Signature: ______________________________