Form A - Use in Paper Format - New Form

Abington Health Physicians

Health Risk Assessment for Medicare Wellness Visit

Print Name:_____ DOB:____/____/____ Today's date____/____/____

GENERAL HEALTH

1. How would you rate your overall health during the past 4 weeks?
   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

2. How have things been going for you during the past 4 weeks?
   - ☐ Very well, could hardly be better
   - ☐ Pretty well
   - ☐ Good and bad parts about equal
   - ☐ Fair
   - ☐ Poor

3. During the past 4 weeks has your physical or emotional health limited your social activities with family, friends or others?
   - ☐ Not at All
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a Bit
   - ☐ Extremely

4. Is there someone who would help you if you become sick or disabled?
   - ☐ Yes ☐ No

   Name_____

   Relationship_____

EMOTIONAL

1. During the last 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or sad?
   - ☐ Not at All
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a Bit
   - ☐ Extremely

PHYSICAL

1. How much bodily pain have you had over the past 4 weeks?
   - ☐ No pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain

2. Do you have problems with:
   - Vision ☐ Yes ☐ No
   - Hearing ☐ Yes ☐ No

3. During the past 4 weeks, how often have you had any of the following problems?

	NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS
Falling or dizziness					
Sexual problems					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					
Tiredness of fatigue					

ACTIVITIES OF DAILY LIVING

1. During the past 4 weeks, did you need help from others to perform everyday activities such as eating, dressing, grooming, bathing or using the toilet?
   - ☐ Yes ☐ No

2. During the past 4 weeks did you need help from others to go shopping, prepare meals, clean your house, manage your money or take medication?
   - ☐ Yes ☐ No

3. Do you have problems with transportation?
   - ☐ Yes ☐ No

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SAFETY

1. Do you always fasten your seat belt when in a car?
   ☐ Yes ☐ No

2. Have you had any recent falls?
   ☐ Yes ☐ No

3. Check any of the following items that you have in your home:
   ☐ Stairs ☐ Night light in the bathroom
   ☐ Handrails on stairs ☐ Throw rugs
   ☐ Handrails in the shower or bath

NUTRITION

1. In the past 7 days how many servings of fruits and vegetables did you typically eat each day?
   # of servings _____

2. In the past 7 days how many servings of high fiber or whole grain foods did you typically eat each day?
   # of servings _____

3. In the past 7 days how many servings of fried or high fat foods did you typically eat each day? (for example: fried foods, fast foods, snack foods, whole milk products, pastries, cheese, mayonnaise)
   # of servings _____

4. In the past 7 days how many sugar sweetened (not diet) drinks did you typically consume each day?
   # of servings _____

LIFESTYLE - HABITS

1. Are you a smoker?
   ☐ No
   ☐ Yes and I am considering quitting
   ☐ Yes, but I'm not ready to quit

2. In an average week, how many days do you drink any alcohol? # of days _____

3. How often do you drink the following amounts: more than 2 drinks for men; more than 1 drink for women?
   ☐ Never or rarely ☐ About once a week
   ☐ Less than once a week ☐ More than once a week

4. In a typical week, how many days do you exercise?
   # of days _____

5. How intense is your typical exercise?
   ☐ Light (stretching or slow walking)
   ☐ Moderate (brisk walking)
   ☐ Heavy (jogging or swimming)
   ☐ Very heavy (fast running or stair climbing)

HOSPITALIZATION

Have you been admitted to a hospital in the past 6 months?
☐ Yes ☐ No

If Yes:
Date _____

Where _____

Reason _____

Date _____

Where _____

Reason _____

I have reviewed the above information with the patient.

Clinician Signature _____

Form must be scanned into ECW

6/13/2012