UB|MD PRIMARY CARE

Medicare Annual Wellness Visit Health Risk Assessment

Patient Name: _____ DOB: _____ Date of Visit: _____

In general, would you say your health is:
- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

Please list the date of your last:

Dental visit: _____

Eye exam: _____
Where did you have your eye exam? _____

In the past 7 days, how many servings of fruits and vegetables did you typically eat **each day**?
(Please circle.)

0 1 2 3 4 5 or more servings per day

(1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables or 1 medium piece of fruit. 1 cup is approximately the size of a baseball.)

In the past 7 days, how many servings of high-fiber or whole-grain foods did you typically eat **each day**?
(Please circle.)

0 1 2 3 4 5 or more servings per day

(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, ½ cup of cooked brown rice or whole wheat pasta.)

In the past 7 days, how many sugar-sweetened beverages did you typically consume each day?
(Please circle.)

0 1 2 3 4 Other: _____ beverages per day

(Sugar-sweetened beverages include drinks such as regular soda/pop, coffee, tea, lemonade, Kool-Aid, sports drinks, energy drinks. Do NOT include 100% fruit juices or diet drinks.)

In the past 7 days, how many days did you exercise? _____
- o On days when you exercised, for how many minutes did you exercise? _____
- o Please describe what you typically do for exercise: _____

In the past 7 days, how much pain have you felt?
- ☐ None
- ☐ Some
- ☐ A lot

Have you had any unintended weight loss **over the past year**? ☐ Yes ☐ No
How fast do you feel you can walk? ☐ Slow ☐ Medium ☐ Fast
How much energy do you feel you have? ☐ Low ☐ Medium ☐ High
How many hours of sleep do you usually get each night? _____

Do you?

Live alone?	☐ Yes	☐ No
Feel safe in your home?	☐ Yes	☐ No
Use sunscreen?	☐ Yes	☐ No
Drive?	☐ Yes	☐ No
Wear seatbelts?	☐ Yes	☐ No

Do you use tobacco products?

☐ Yes, current user ☐ Never used tobacco ☐ Former tobacco user - Quit year: _____

If yes, are you interested in quitting? ☐ Yes ☐ No

Do you use recreational/street drugs? ☐ Yes ☐ No

Do you have the following in your home?

Stairs?	☐ Yes	☐ No
Area rugs?	☐ Yes	☐ No
Smoke detectors?	☐ Yes	☐ No
Carbon monoxide detectors?	☐ Yes	☐ No
Pets?	☐ Yes	☐ No
Unsecured firearms?	☐ Yes	☐ No

On <u>more than half the days</u> over the past <u>2 weeks</u>, have you felt:

Nervous or anxious?	☐ Yes	☐ No
Stress has interfered with your obligations?	☐ Yes	☐ No
Anger has interfered with your relationships with others?	☐ Yes	☐ No

Activities of Daily Living	Do you need help with any of the following?		If yes, do you have the help you need?		
Preparing your own meals	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Shopping	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Paying bills or managing checkbook	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Housework/laundry	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Using phone	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Transportation in community	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Travelling by train/bus/plane	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Taking medications	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Moving from bed to chair	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Feeding yourself	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Dressing	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Bathing	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Grooming	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Using the toilet	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A

Falls Assessment

Do you feel afraid of falling? ☐ Yes ☐ No

Have you fallen within the past year? ☐ Yes ☐ No

If Yes, how many times have you fallen this year?

☐ 1 time without injury

☐ with injury

☐ 2 or more times

Urinary Incontinence Assessment

Many people experience problems with urinary incontinence, the leaking of urine.

In the past 6 months, have you accidentally leaked urine? ☐ Yes ☐ No

If Yes to urine leakage, how much of a problem, if any, was the urine leakage for you?

☐ A big problem ☐ A small problem ☐ Not a problem

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UBMD PHQ-9 QUESTIONNAIRE

<u>Over the past two weeks</u>, how often have you been bothered by the following problems?	**Not at all (0)**	**Several days (1)**	**Half of days or more (2)**	**Nearly every day (3)**
Little interest or pleasure in doing things				
Feeling down, depressed, irritable, or hopeless				
Trouble falling or staying asleep or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or feeling that you are a failure or have let yourself or your family down				
Trouble concentrating on things, like reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed or the opposite - being so fidgety or restless that you were moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				
If you are experiencing any of the problems on this form, how difficult have these problems made it for you to work, take care of things at home or get along with other people? ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult				