Sparks Clinic
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# 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 | | | |

# HEALTH RISK ASSESSMENT

## 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

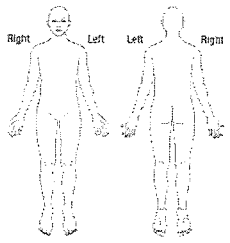
## PAIN ASSESSMENT, CPT II CODES 1125F, 1126F

**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?

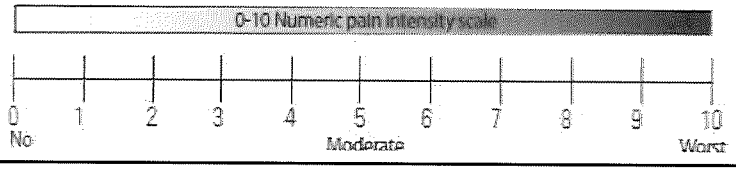
☐ No pain
**or**
Mark all areas indicated on the image




**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



# HEALTH RISK ASSESSMENT

| 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 | |

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

| Name | Dose | Date started | Condition treating |
|---|---|---|---|
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## 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 | | |
| | | |
| | | |

| ALLERGIES (DRUG, FOOD, ENVIRONMENT) | |
|---|---|
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| OFFICIAL USE ONLY | |
|---|---|
| **Reviewed by**<br>**Clinician name:** | |
| **Clinician signature:** | **Date:** |