

Medicare Health Risk Assessment (HRA) For Annual Wellness Visits



Patient Name _____ Date of Birth ____/____/____

PHYSICAL ACTIVITY/ EXERCISE

How many days a week do you usually exercise?

_____ days per week _____ amount of time spent exercising

How intense is your typical exercise?

- Light (stretching or slow walking) Moderate (brisk walking) Heavy (jogging or swimming)
 Very heavy (running or stair climbing) I am currently not exercising

SMOKING STATUS Do you currently smoke cigarettes or use other types of tobacco?

- Current smoker Former smoker Never a smoker

ALCOHOL USE

In a typical week, how often do you have one or more alcoholic drinks on one occasion?

- No alcohol use Moderate (Men: two per day or less; Women: one per day or less)
 Social drinker Alcohol use (3 or more per day)

NUTRITION Do you eat fiber, fruits, and vegetables? Yes No

ORAL HEALTH Do you see a dentist yearly? Yes No

HEARING

Do you have difficulty hearing when someone speaks in a whisper? Yes No

Do you have hearing problems when in a crowd? Yes No

Does a hearing problem cause you to argue with family members? Yes No

SLEEP

How many hours of sleep do you get each night? _____

ACTIVITIES OF DAILY LIVING

Do you feel that you need assistance with dressing, feeding, or bathing? Yes No

Do you have feelings of unsteadiness including balance? Yes No

Over the past year I have:

_____ Not experienced a fall _____ Had one fall with injury

_____ Had one fall without injury _____ Had two or more falls

Do you need assistance with shopping, food preparation, housekeeping, laundry or transportation? Yes No

Do you need help with your medications? Yes No

Do you need assistance with handling financial affairs? Yes No

MOTOR VEHICLE SAFETY Do you wear a seatbelt every time you are in an automobile? Yes No

SUN EXPOSURE When outdoors, do you wear sunscreen? Yes No

HOME SAFETY Do you have working smoke and fire detectors in your home? Yes No

HIGH STRESS

How well do you handle the stress in your life?

I'm usually able to cope effectively At times I have problems coping I often have problems coping

How often is stress a problem for you? Never/Rarely Sometimes Often Always

GENERAL WELL-BEING

In general, would you say your health is? Excellent Very good Good Fair Poor

DEPRESSION

Over the past 2 weeks how often, have you experienced loss of pleasure from your usual activities?

Not at all Several days More than half the days Nearly every day

Over the past 2 weeks how often, have you been bothered by feelings of sadness, depression, or helplessness?

Not at all Several days More than half the days Nearly every day

Have your feelings caused you distress or interfered with your ability to interact socially with friends?

Yes No

Generally, how satisfied are you with your life?

Very satisfied Satisfied Dissatisfied Very dissatisfied

SOCIAL/EMOTIONAL SUPPORT

How often do you get the social and emotional support you need:

Always Usually Sometimes Rarely Never