MAB
MEDICAL ASSOCIATES
OF BREVARD

Medicare Annual Wellness Visit Health Risk Assessment

Today's Date: _____

Patient Name: _____ DOB: _____

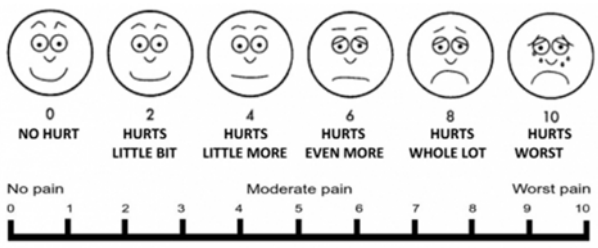
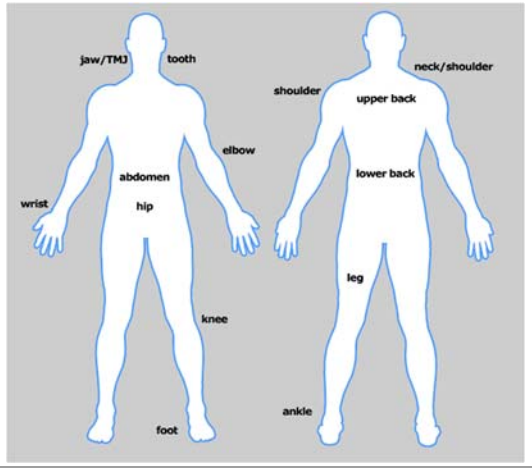
PERSONAL INFORMATION	
What is your primary language spoken at home?	English Spanish Other:
How do you prefer we communicate?	Phone/Text: (#_____-_____-_____) E-mail:
Do you use a local pharmacy?	Yes No Name: Phone Number: (#_____-_____-_____)
GENERAL HEALTH	
How is your overall health?	Excellent Good Fair Poor
How confident are you that you can manage most of your health problems?	Confident Somewhat Not very confident Don't have any health concerns
What are your biggest concerns about managing your health? ***Check all that apply***	o None o I live in an unsafe environment o Transportation to appointments o Financial difficulty in paying for services/medicines o I have difficulty taking or remembering my medicines o Difficulty reading or understanding instructions o I am lonely or don't have a lot of support at home o I am often very tired o I experience a lot of stress or anger o I fall a lot at home
How many times in the last 6 months have you been to the emergency room?	0 1-2 3-4 5+ I don't know
How many times in the last 6 months have you been admitted to the hospital?	0 1-2 3-4 5+ I don't know
Please list any new healthcare providers you have seen since your last visit with us.	
How many different prescriptions are you taking?	0-3 4-6 7-10 10+ I don't know
Please list any new medicines you have started since your last visit with us.	
Have you had any problems with your teeth or dentures?	Yes No
Are you having any sexual problems you would like to discuss?	Yes No
Do you or your family members have any concerns about your memory?	Yes No

Please list any updates to your Family Medical History (family conditions that your doctor may not know about):	
TOBACCO, ALCOHOL AND DRUG USE	
Do you use any tobacco products? (Cigarettes, chew, snuff, pipes, cigars)	Yes No
If so, are you interested in quitting tobacco?	Yes No I don't use tobacco
How many times in the past year have you had 4 or more drinks in a day?	Daily-or-almost-daily Weekly Monthly Once-or-twice Never
Do you use any illegal drugs or take any prescription medications that have not been prescribed to you?	Yes (please describe): No
NUTRITION	
Do you follow any special diet? (low sodium/cholesterol/fat?)	Yes No
Do you use any dietary supplements, including meal replacement drinks?	Yes No
In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?	0 1-2 3-4 I don't know
PHYSICAL ACTIVITY	
How many days a week do you exercise?	0 1-2 3-4 5+ I don't know
How intense is your exercise?	Light Moderate Heavy Very Heavy I don't know I don't exercise
SLEEP	
How many hours of sleep do you usually get?	0-3 4-6 7-10 10+ I don't know
Do you snore, or has anyone told you that you snore?	Yes No I don't know
In the past 7 days, how often have you felt sleepy during the day?	Often Sometimes Almost Never Never
Have you ever been diagnosed with Sleep Apnea or other sleep disorders?	Yes No I don't know
Are you currently using or have you used C-PAP/Bi-PAP?	Yes No

DEPRESSION SCREENING (PHQ-2)				
In the past 2 weeks, how often have you been bothered by the following problems:	**Not at all:**	**Several Days:**	**More than half of those days:**	**Nearly every day:**
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**

Total Score:	

FUNCTIONAL STATUS ASSESSMENT	
Activities of daily living (ADL's) - Please circle those that apply.	
Which of the following can you do on your own without help?	Bathe Dress Eat Walk Use the restroom Transfer in/out of chairs, etc. None
Does someone help you at home? If yes, please provide Caregiver Name:	Yes No Spouse Children Other: Aide/Caregiver #:
Many people experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experienced leaking of urine?	Yes When cough/sneeze No I don't know
Instrumental activities of daily living (IADL's) - Please circle those that apply.	
Which of the following can you do on your own without help?	Shop for groceries Use the telephone Housework Handle finances Drive/Use public transportation Take Medications Make meals None
HOME/SAFETY	
What is your housing situation like? *Check all that apply*	o Live with one or more children or dependent o Live in an assisted living facility o Live in a nursing facility o Live alone o I have housing today, but I am worried about losing housing in the future o I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

Do you have a problem with any of the following at your home? ***Check all that apply***	o Bug infestation o Mold o Lead paint or pipes o Inadequate heat o Oven or stove not working o No or not working smoke detectors o Water leaks o None of the above
Do you feel safe in your home?	Yes No
Does your home have working smoke alarms?	Yes No I don't know
Do you have throw rugs on your floor(s)?	Yes No
Do you have handrails in the bathroom?	Yes No
Do you have proper lighting in your home?	Yes No
Do you have handrails for the stairs?	Yes No I don't have stairs
Do you fasten your seatbelt in vehicles?	Yes No I don't ride in vehicles
PAIN ASSESSMENT	
In the past 2 weeks, how often have you felt pain?	Almost all of the time Most times Sometimes Almost never Never
Where is the pain? ***Mark all areas in which pain is present.*** Rate your pain on the following scale:  	
How do you treat the pain?	Medication Rest Heat/Cold Therapy I don't treat my pain
RISK FOR FALLING	
Which of these assistive devices do you use? ***Please circle all that apply***	Cane Walker Wheelchair Crutches Other None
Do you have trouble with your balance?	Yes No
Have you fallen 2 or more times or have had a fall with injury in the past year?	Yes No
Are you afraid of falling?	Yes No
Do you have any amputations?	Yes No If yes, where?:
SENSORY ABILITY *(please circle all that apply)*	

Do you have problems with vision? Eye Doctor name:	Yes No If yes, please identify: Legally blind Cataracts Diabetic Retinopathy Other:
Do you use eyeglasses or contacts?	Yes No
Do you have problems with your hearing? ENT/Hearing Specialist name:	Yes No If yes, please identify: Partial hearing loss Deaf TTY Other:
Do you use hearing aids or other devices to help you hear?	Yes No
SOCIAL/EMOTIONAL SUPPORT *(please circle all that apply)*	
Which of the following applies to you? ***Please check all that apply***	● I have a supportive family ● I have supportive friends ● I participate in church, clubs, or other groups ● None
How often do you get out and meet with family and friends?	Often Sometimes Almost Never Never
Describe your current living situation.	Alone Spouse Children. Homeless Assisted Living Facility Don't have a stable home
ADVANCE DIRECTIVES	
Does your family or friends know what you want in an emergency situation or if you could not speak for yourself? ***Check all that apply*** *If you have any of the following, it would be helpful to have a copy provided to us for your medical record.*	No Yes, and I have completed: ❑ A living will (Advance Directive) ❑ Power of Attorney for Health Care ❑ POLST (in some states known as: POST, MOST, MOLST, TPOPP) ❑ Five wishes
Would you like more information?	Yes No Unsure

ALLERGIES – Drugs, Food, Environment		

MEDICATIONS – Prescriptions, Vitamins, Over-the-Counter			
Name	Dose	Date Started	Condition Treating

SELF & 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						
Depression						
Significant Surgeries:						

OTHER PHYSICIANS/ HEALTHCARE PROVIDERS		
Specialty	**Physician Name**	**Last Seen**
Cardiologist		
Dermatologist		
Ear, Nose, & Throat (ENT)		
Endocrinologist		
Eye/Optometry/Ophthalmologist		
Gastroenterologist		
Gynecologist		
Hematologist/Oncologist		
Nephrologist		
Neurologist		
Orthopedist		
Podiatrist		
Pulmonologist		
Psychiatrist/Psychologist		
Rheumatologist		
Urologist		
Other:		

*This additional PHQ-9 screening should only be provided to the patient to complete, or be conducted through patient interview by a clinical staff member, **IF** the PHQ-2 was positive.

DEPRESSION PHQ-9				
In the past 2 weeks, how often have you been bothered by the following problems:	**Not at all:**	**Several Days:**	**More than half of those days:**	**Nearly every day:**
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself, or that you're a failure, or have let yourself or family down	**0**	**1**	**2**	**3**
Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
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	**0**	**1**	**2**	**3**
Thoughts that you would be better off dead, or of hurting yourself	**0**	**1**	**2**	**3**
Total Score:				
If you checked off any of the 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