Medicare Health Risk Assessment

In order for Medicare to pay for a wellness visit, the patient MUST complete a Health Risk Assessment form. Please take the time to fill it out prior to your visit. If you need assistance, our staff will be happy to help you.

Name: ___________________________ Date of Birth: ___________________________

In general would you say your health is:

☐ Excellent    ☐ Very Good    ☐ Fair    ☐ Poor

EXERCISE:
Do you exercise regularly?  ☐ YES  ☐ NO
If yes, please describe below.

Type: ___________________________ How Often: ___________________________

DIET:
In an average week, how many ½ cup servings of the following do you eat?
Fruits _______ Vegetables _______

In an average week, how many 4 ounce servings of the following do you eat?
Red Meat (Beef/Pork) _______ Chicken _______ Fish _______ Fried Foods _______

In an average week, how many servings of dairy do you eat?
(1 cup milk, 1.5 oz natural cheese, 1 oz processed cheese, 6 oz yogurt, ½ cup ice cream)
Dairy _______

ALCOHOL:
Do you drink alcohol?  ☐ YES  ☐ NO
If yes, please describe below.

How many drinks per day?___________ or per week?____________

ILLEGAL DRUG USE:
Do you currently, or have you in the past, used illegal drugs?  ☐ YES  ☐ NO
If yes, please describe below.

_________________________________________
TOBACCO:
Do you currently smoke?  ○ YES  ○ NO
If yes, how much?___________

Have you smoked in the past?  ○ YES  ○ NO
If yes, when did you quit?___________

Do you currently, or have you in the past chewed tobacco or used snuff?  ○ YES  ○ NO

FUNCTIONAL EVALUATION:
Do you need help with bathing, dressing, walking, shopping, preparing meals, housework, medications, or managing money?
○ YES  ○ NO

Do you have rugs at home, lack grab bars in the bathroom, lack hand rails on the stairs or have poor lighting?
○ YES  ○ NO

SELCARE:
Do you have a problem with your vision?  ○ YES  ○ NO
Do you have a problem with your hearing?  ○ YES  ○ NO
Do you wear hearing aids?  ○ YES  ○ NO
Do you have a problem with your memory?  ○ YES  ○ NO
Do you have a living will?  ○ YES  ○ NO
(If yes, please bring a copy to your visit)
Do you have a medical power of attorney?  ○ YES  ○ NO
(If yes, please bring a copy to your visit)

List all other doctors, specialists, and healthcare providers rendering care:
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________