MEDICARE WELLNESS HEALTH RISK ASSESSMENT (HRA)

Annual Wellness Visit/ Initial Preventative Physical Examination

Patient Name: _____ Date of Birth: _____

Thank you for trusting GCH Clinics for your Annual Medicare Wellness Exam. Please complete the following Health Risk Assessment. This information will be used to create your Personalized Preventative Plan based on your visit today.

Medicare Wellness - Personal Health Assessment

In general, how would you rate your health?	Excellent	Very Good	Good	Fair	Poor
How often is stress a problem for you?	Never	Rarely	Sometimes	Usually	Always
How often is pain a problem for you?	Never	Rarely	Sometimes	Usually	Always

Do you exercise on a regular basis?	Yes	No	
Do you have difficulty walking or getting around?	No	Yes	
Do you have difficulty dressing, bathing or grooming yourself?	No	Yes	
Have you had any vision changes in the last year?	No	Yes	
Do you have any hearing difficulty when listening to the TV or radio?	No	Yes	
Do you have problems with your teeth or gums?	No	Yes	
How many times per day do you eat?	3	2	1
Have you accidentally leaked urine in the last 6 months?	No	Yes	
How many times do you get up at night to use the bathroom?	0	1	2

Medicare Wellness - Assistance Required

Do you need support to get in and out of the bathtub or up from a chair?	No	Yes
Do you need help with housekeeping?	No	Yes
Do you need help with your medications?	No	Yes
Do you need help with preparing meals?	No	Yes
Do you need help with transportation?	No	Yes
Do you need help managing your finances?	No	Yes
Do you have someone you could call if you need help?	Yes	No

Medicare Wellness - Environmental Health Risks

Are the main pathways in your home free of tripping hazards such as furniture, wires/cords or throw rugs?	Yes	No
Do you have adequate lighting in your home and nightlights in your hallways?	Yes	No
Do you have working smoke detectors?	Yes	No
Do you have nonslip mats in the bathtub or shower?	Yes	No
Do you always wear your seatbelt when in a vehicle?	Yes	No

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Medicare Wellness - Depression Screening

Have you felt little interest or pleasure in doing things over the past 2 weeks?	Not at all	Several days	More than half the days	Nearly every day
Have you felt down or depressed or hopeless over the past 2 weeks?	Not at all	Several days	More than half the days	Nearly every day

Medicare Wellness - Fall Risk Screening

Have you fallen in the past year?	No falls	One fall without injury	Any fall with injury	2 or more falls
Do you feel unsteady when standing or walking?	No		Yes	
Are you worried about falling?	No		Yes	

Medicare Wellness - Advanced Directives

Do you have a POLST, or if you live in Iowa, an IPOST (Physician Orders for Life-Sustaining Treatment)?	Yes	No	
What date was your POLST/IPOST initiated?	Date:		
Which advanced directives documents do you have completed?	Living Will	Power of Attorney for health care	Power of Attorney for finance
	Guardianship	Protective placement	Conservatorship
	Representative Payee	Mental Health Advocate	Other

Your Health Care Team

Please list all current physicians and other health care providers from whom you receive care or services:
If none, check this box:

Physician/Provider Name	Specialty	Reason