PASEO FAMILY PHYSICIANS

Patient Name:_____

Date of Birth:_____

Today's Date:_____

MEDICARE HEALTH RISK ASSESSMENT

Please complete this form before seeing your doctor. Your responses will help you receive the best health and health care possible.

1. During the **past four weeks**, have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

☐ Yes ☐ No

2. During the **past four weeks**, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

☐ Yes ☐ No

3. During the **past four weeks**, how much bodily pain have you generally had?

- ☐ No pain
- ☐ Very mild pain
- ☐ Mild pain
- ☐ Moderate pain
- ☐ Severe pain

4. During the **past four weeks**, was someone available to help you if you needed and wanted help?

- ☐ Yes, as much as I wanted
- ☐ Yes, quite a bit
- ☐ Yes, some
- ☐ Yes, a little
- ☐ No, not at all

5. Can you handle your own money without help?

☐ Yes ☐ No

6. During the **past four weeks**, what was the hardest physical activity you could do for at least 2 minutes?

- ☐ Very heavy
- ☐ Heavy
- ☐ Moderate
- ☐ Light
- ☐ Very Light

7. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)

☐ Yes ☐ No

8. Can you go shopping for groceries or clothes without someone's help?

☐ Yes ☐ No

9. Can you prepare your own meals?

☐ Yes ☐ No

10. Can you do your housework without help?

☐ Yes ☐ No

11. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

☐ Yes ☐ No

12. During the **past four weeks**, how would you rate your health in general?

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very Good
- ☐ Excellent

Patient Name:_____ DOB:_____

13. Are you having difficulties driving your car?

☐ Yes
☐ No
☐ Not Applicable (I don't drive)

14. Do you always fasten your seat belt when you are in a car?

☐ Yes ☐ No

15. How often during the **past four weeks** have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up	☐	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐	☐
Trouble eating well	☐	☐	☐	☐	☐
Teeth or denture problems	☐	☐	☐	☐	☐
Problems using the telephone	☐	☐	☐	☐	☐
Tiredness or fatigue	☐	☐	☐	☐	☐

16. Have you fallen two or more times in **the past year**?

☐ Yes ☐ No

17. Are you afraid of falling?

☐ Yes ☐ No

18. Are you currently a smoker?

☐ Yes ☐ No

19. Do you exercise for about 20 minutes three or more days a week?

☐ Yes ☐ No

20. Would you like any information to help you with the following?

Hazards in your house that might hurt you?

☐ Yes ☐ No

Keeping track of your medications?

☐ Yes ☐ No

21. How often do you have trouble taking medicines the way you have been told to take them?

☐ I do not take medicine
☐ I always take them as prescribed
☐ I sometimes take them as prescribed
☐ I seldom take them as prescribed

22. How confident are you that you can control and manage most of your health problems?

☐ Very confident
☐ Somewhat confident
☐ Not very confident
☐ I do not have any health problems

23. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?

☐ 10 or more drinks per week
☐ 6-9 drinks per week
☐ 2-5 drinks per week
☐ One drink or less per week
☐ No alcohol at all

Thank you for completing your Medicare Health Risk Assessment form.

Please give the completed form to your physician's medical assistant.

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