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Annual Wellness Visit Health Risk Assessment

To Our Patients:

This Health Risk Assessment Questionnaire is part of your upcoming Wellness Visit. Please answer the following questions about your health and day to day activities.

This questionnaire will help your clinical team address the areas important to your overall well- being.

This questionnaire should take about 5 minutes to complete.

If you need help, please contact our office, or ask for help during your visit.

Thank you.

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Patient Label

Please answer the following questions to the best of your ability.

1. In general, how would you rate your overall health?

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

2. In general, how would you rate your quality of life?

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

3. In general, how would you rate your mental health?

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

4. In the **past 7 days**, how much did your pain interfere with your day to day activities?

☐ Not at all	☐ A little bit	☐ Somewhat	☐ Quite a bit	☐ Very much

5. Over the **last two weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐

6. Because of a health or physical problem, do you have any difficulty doing the following activities **without special equipment or help from another person**

	I do not have difficulty	Yes, I have difficulty	I am not able to do this activity unassisted
Bathing			
Dressing and grooming			
Eating			
Using the toilet			
Getting in and out of bed or chairs			
Managing medications			
Managing money			
Household activities, like food prep, laundry, and housekeeping			
Can you shop for groceries and clothes?			
Can you get to places out of walking distance?			

7. In the past 6 months, have you accidentally leaked urine?

☐ Yes	☐ No

8. A fall is when your body goes to the ground without being pushed. Did you fall in the **past 12 months**?

☐ Yes	☐ No

If yes, how many times?_____Were you Injured? _____

Do you feel unsteady when standing or walking?

☐ Yes	☐ No

Do you worry about falling?

☐ Yes	☐ No

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9. What is your walking status?

☐ Walk unassisted	☐ Use a cane or walker	☐ Use a wheelchair

10. Do you think you have a hearing problem, or do others think you have a hearing problem?

☐ Yes	☐ No

11. Do you wear hearing aids?

☐ Yes	☐ No

12. Do you have difficulty driving, watching TV, reading, or doing any of your daily activities?

☐ Yes	☐ No

13. How is your appetite?

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

14. How many servings of fruits and vegetables do you eat on a typical day?

☐ More than 5	☐ 3-5 servings	☐ 1-2 servings	☐ I do not eat fruit and vegetables

15. Does the place where you live have the following safety concerns addressed?

	Yes	No
Loose rugs secured	☐	☐
Carbon Monoxide detector	☐	☐
Working smoke alarm	☐	☐
Good lighting in walkways	☐	☐
Solid hand rails on stairs	☐	☐
Non-slip flooring in tub or shower, or grab bars	☐	☐

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15. What is your usual form of transportation?

☐ Drive self	☐ Driven by others	☐ Bus/taxi/paratransit

16. Is your Advance Healthcare Directive on file with us?

☐ Yes	☐ No

17. In the past four weeks, would there have been someone available (family, friend, etc.) to help you if you would have needed and wanted the help? For example. If you felt lonely, depressed, got sick and needed to stay in bed, needed help with daily chores, or just needed to take care of yourself.

Yes, as much as ☐ needed	Yes, quite a ☐ bit	☐ Yes, some	☐ Yes, a little	No, not at ☐ all

18. How many days per week do you usually exercise? _____

19. If you exercise, on average, how long is your exercise session? _____

20. How intense is your physical exercise?

Very heavy running, stair ☐ climbing	Heavy jogging, ☐ swimming	Moderate brisk ☐ walking	Light stretching or ☐ slow walking

21. In a typical week, how many days do you drink alcohol (beer, wine, liquor, cocktails)?
_____day(s) a week

22. On days when you do drink how many alcoholic drinks do you consume? _____
(one drink= 12 oz of beer, 5 oz. of wine, or 1.5 oz. of distilled spirits)

23. What is the most number of drinks you've had in one day in the past 6 months? _____

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24. To ensure optimal care coordination, please list below all providers you see on a regular basis.

_____

_____

_____

_____

_____

Please wait for your provider to complete this portion