Medicare Health Risk Assessment

Patient Name: _____ DOB: _____ Visit Date: _____

Please complete this checklist before seeing your provider. Your responses will help us make sure you get the best health care possible.

	General Questions	Yes	No
1	Do you have any concerns that you would like to discuss with your health care provider?		
2	Because of 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? *If yes, Circle which one(s)*		
3	Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? *If yes, Circle which one(s)*		
4	Do you have problems taking your medications as prescribed?		
5	Do you feel that you need to exercise more? If no, list activities and how often. _____ _____		
6	Do you have new or changing moles you are concerned with?		
	Functional Status and Safety		
1	Are you afraid of falling?		
2	Have you fallen two or more times in the past year?		
3	Have you noticed any hearing difficulties?		
4	In the past year have you ever lost bladder control? If so, has it occurred on at least six separate days?		
5	Do you feel Unsafe at home?		
	Drug/Alcohol/Tobacco Use:		
1	Do you currently smoke, vape or chew? If yes, how many years and how much daily? _____ If no, did you previously and what date did you quit?_____		
2	Do you drink wine, beer, or other alcoholic beverages? If yes, what kind and how much per day? _____		
3	Have you used drugs or supplements not prescribed? If yes, what have you used? _____		

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	Coordination of Care	Yes	No
1	Do you have other doctors that you regularly see? If yes, who: _____		
2	Do you have a dentist? If yes, who do you see and when was your last appointment: _____		
3	Do you have an eye doctor? If yes, who: _____		
2	Do you purchase medical supplies on a regular basis? (ex: Oxygen, Cpap Supplies,etc.) If yes, from who: _____		
3	Do you receive care from a Home Health or Hospice agency? If yes, who: _____		
	Shelter Factors		
1	Do you live at an assisted living facility or nursing home? Facility name: _____		
2	Do you have Unstable housing?		
3	Are you WITHOUT a smoke detector and carbon monoxide sensor in your home?		
	Advance Care Planning		
1	Are you WITHOUT an advanced directive such as DNR Directives or Living Will?		

Patient Health Questionnaire (PHQ-9)

Over the *last 2 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
a. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
b. Feeling down, depressed, hopeless, or anxious	**0**	**1**	**2**	**3**
If your Total score for questions "a" and "b" are LESS THAN "3" STOP HERE. Otherwise, please complete "c" thru "j"				
c. Trouble falling/staying asleep, sleeping to much	**0**	**1**	**2**	**3**
d. Feeling tired or having little energy	**0**	**1**	**2**	**3**
e. Poor appetite or overeating	**0**	**1**	**2**	**3**
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
g. Trouble concentrating on things, such as reading the newspaper or watching tv	**0**	**1**	**2**	**3**
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	**0**	**1**	**2**	**3**
i. Thoughts that you would be better off dead or of hurting yourself in some way	**0**	**1**	**2**	**3**
j. If you checked off any problem on this questionnaire so far, how difficult have these problems made if it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Please give this completed form to your nurse. (Rev. 09-2018)