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MEDICARE HEALTH RISK ASSESSMENT QUESTIONNAIRE

General health

1. Compared to other people your age, how would you describe

	Excellent	Good	Fair	Poor
Your overall health	☐	☐	☐	☐
Your quality of life	☐	☐	☐	☐
Mental health (including mood, memory and ability to think)	☐	☐	☐	☐

2. Over the last 4 weeks how often have you experienced the following?

	Never	Seldom	Sometimes	Often	Always
Bladder control problems (urine leaking)	☐	☐	☐	☐	☐
Teeth, denture or oral problems	☐	☐	☐	☐	☐
Problems with your hearing	☐	☐	☐	☐	☐
Problems seeing (even with your glasses)	☐	☐	☐	☐	☐
Ridden in a car **without** wearing a seatbelt	☐	☐	☐	☐	☐
Pain interfering with your day to day activities?	☐	☐	☐	☐	☐
Feeling stressed or overwhelmed	☐	☐	☐	☐	☐
Tiredness or fatigue	☐	☐	☐	☐	☐
Anger or frustration	☐	☐	☐	☐	☐
Loneliness or social isolation	☐	☐	☐	☐	☐

3. Do you have any difficulty communicating with your health care team?

☐ Difficulty reading	☐ Need interpreter	☐ Unable to read	☐ Difficulty hearing	☐ N/A; I have no difficulties

Physical Activity and Nutrition

4. How many servings of fruits and vegetables do you eat in a typical day?
(1 serving = 1 piece of fruit, 1/2 cup fruits or vegetables)

☐ More than 5	☐ 3-5	☐ 1-2	☐ None

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5. Do you do moderate to strenuous exercise (brisk walk) for about 20 minutes for 3 or more days per week?

☐ Yes, most of the time	☐ Yes, some of the time	☐ No, I usually do not exercise this much	☐ No, but I am active with housework or yard work

Functional Status

6. During the past 4 weeks, was someone available to help if you needed/wanted help?

☐ Yes, as much as I wanted	☐ Yes, quite a bit	☐ Yes, some	☐ Yes, a little	☐ No, not at all	☐ N/A; I did not need help

7. Activities of daily living

	Independent	Minimal Supervision	Needs Assistance	Totally Dependent	Assistive Device
Walking	☐	☐	☐	☐	☐
Bathing/Grooming	☐	☐	☐	☐	☐
Getting dressed	☐	☐	☐	☐	☐
Using the toilet	☐	☐	☐	☐	☐
Feeding yourself	☐	☐	☐	☐	☐
Managing your medications	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐
Managing money	☐	☐	☐	☐	☐
Doing housework	☐	☐	☐	☐	☐
Getting groceries or other errands	☐	☐	☐	☐	☐

Home/Safety/Social

8. What is your living situation?

☐ alone	☐ spouse/ significant other	☐ family members	☐ friends/ roommates
☐ skilled nursing	☐ assisted living	☐ senior living community	☐ other

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9. Do you have any safety concerns where you live? (please select all that apply)

☐ Rugs not secure/ non slip	☐ Inadequate lighting	☐ Missing carbon monoxide monitor	☐ Missing or outdated smoke detector
☐ Clutter, loose cords	☐ Shower/tub slippery	☐ No grab bars where needed	☐ No stair railing or unstable steps
☐ N/A; I have no safety concerns			

10. Are you a smoker?

☐ No, never	☐ Former	☐ Yes, and I might quit	☐ Yes, but I'm not ready to quit

11. How often do you have a drink containing alcohol?

☐ Never	☐ Monthly or less	☐ 2-4 times/ month	☐ 2-3 times/ week	☐ 4 or more times/week

12. IF you drink alcohol, how many standard drinks containing alcohol do you have on a typical day when you are drinking?
(12 oz of beer, 8 oz of malt liquor, 5 oz of wine, "shot" of distilled spirits or liquor)

☐ N/A	☐ 2 or fewer	☐ 3 or 4	☐ 5 or 6	☐ 7, 8 or 9	☐ 10 ormore

Fall Risk Screening

	Yes	No
Did you fall anytime in the last year?	☐	☐
If yes how many times?		
Were you injured?	☐	☐
Do you feel unsteady when standing or walking?	☐	☐
Do you worry about falling?	☐	☐

Depression Screening

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	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐

if Score > 2 administer PHQ-9

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Give this sheet to your provider

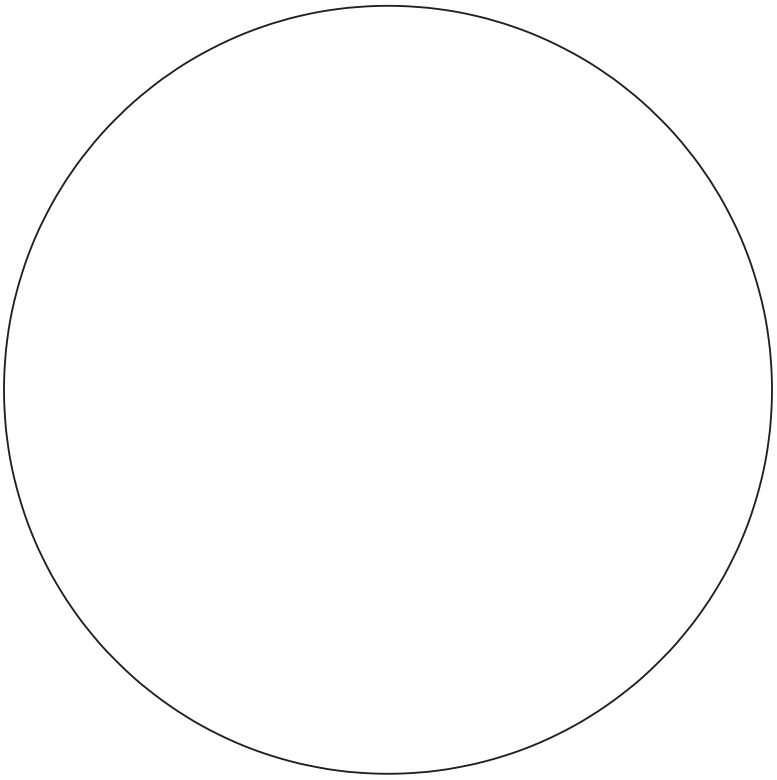
To ensure optimal care coordination, please list below all providers you see on a regular basis.

_____

_____

_____

_____



_____ _____ _____

DATE TIME SIGNATURE (Patient/Legal Designated Representative)

_____ _____

PRINT NAME RELATIONSHIP TO PATIENT

If an interpreter participated in this discussion:

_____ _____ _____

PRINT SMP in-person interpreter name Video or TEL Interpreter ID# Language

_____ _____ _____ _____

DATE TIME PHYSICIAN SIGNATURE PRINT NAME