**Medicare Health Risk Assessment Questionnaire**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please check the appropriate box that answers the questions below and write any additional pertinent information that will help us meet your needs better.***

1. What is your primary language? □ English □ Spanish □Other:\_\_\_\_\_\_\_\_

2. Where do you currently live?

□ Live in an independent house, apartment, mobile home

□ Live in an assisted living apartment, or board & care: Name: \_\_\_\_\_\_\_\_\_

□ Live in a nursing home: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What is your current living arrangement? (check each that applies)

□ Live alone

□ With spouse/significant other

□ With child(ren)

□ With other relative(s)

□ With non-relative(s)

□ With paid caregiver

4. Do you plan on changing your present living arrangements in the next 6 months?

□ Yes □ No If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Do you know the name of your current Primary Care Physician (PCP)?

□ Yes, Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ No

6. Have you seen your current PCP in the last 3 months? □ Yes □ No

6a. If no, do you have a scheduled PCP appointment? □ Yes □ No

7. Are you under the care of a Specialist, if yes, Name & Specialty?

□ Yes, Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ No

8. Have you been to the Emergency Room in the past 6 months?

□ Yes, how many times: \_\_\_\_\_\_ □ No

9. Have you stayed overnight in a hospital in the past 12 months?

□ Yes, how many times: \_\_\_\_\_\_ □ No

10. Have you been in a Skilled Nursing Facility in the past 12 months?

□ Yes, how many times: \_\_\_\_\_\_ □ No

11. In general, would you say your health is (Check one answer)

□ Excellent □ Very Good □ Good □Fair □Poor

12. For each of the activities, indicate whether: you are able to do this without help,

or, needs some help performing activity:

Needs some help Able to do this without help

Using the toilet □ □

Bathing □ □

Dressing □ □

Eating □ □

Getting in/out of bed or chair □ □

Walking □ □

Managing money □ □

Taking medications □ □

Preparing meals □ □

Shopping and errands □ □

Housekeeping chores □ □

Using the telephone □ □

13. If you receive help with any of these activities selected in above question, who is

the helper?(name, relationship and phone number if we may contact your helper)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Phone Number

14. Do you use any of the following special equipment **because of a disability or**

**health problem?**

Yes No

□ □ Walker

□ □ Bedside Commode

□ □ Wheelchair

□ □ Hoyer Lift

□ □ Cane

□ □ Grab Bars

□ □ Bath Bench

□ □ Hospital Bed

□ □ Ramps

□ □ Raised Toilet Seat

15. Are you currently being treated for any of the following health conditions?

For any yes answers, please describe.

Yes No

□ □ Dialysis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Memory Loss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Urinary Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Breathing Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Circulation Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Osteoporosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Stomach/Bowel Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Recent Fracture (last 12 months) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Parkinson’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Ankle/Leg Swelling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Uncorrected Hearing Loss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Congestive Heart Failure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ If you have Congestive Heart Failure, have you been hospitalized for it in

the last 12 months?

□ □ Other (Describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15a. Have you ever been treated for the following conditions? If yes, describe.

Yes No

□ □ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Heart Attack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Chest Pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. Do you have Diabetes? □ Yes □ No

16a. If Yes, have you had a Diabetic Eye Exam done in the past year?

□ Yes □ No/Don’t know

16b. If No, have you had a Glaucoma (Eye Pressure) Screen done in the past year?

□ Yes □ No/Don’t know

17. How is your eyesight? (while wearing glasses or contacts, if applicable).

□ Excellent □ Good □ Fair □ Poor □Blind

18. Are you currently receiving any of the following services from an agency?

Yes No

□ □ Home Health Nurse

□ □ Physical, Occupational, Speech Therapy at Home

□ □ Home Health Aide

□ □ Social Worker

□ □ Adult Day Care Center

□ □ Assistance with Transportation

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19. Do you currently use or receive any of the following?

Yes No

□ □ Feeding Tube

□ □ Oxygen

□ □ Colostomy Care

□ □ Catheter Care

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. Which of the following statements fits you best in terms of health? Check all that apply.

□ Must stay in bed all or most of the time because of physical limitations

□ Must stay in the house all or most of the time because of physical limitations

□ Need the help of another person in getting around inside or outside the house

□ Need the help of some special aid, like a cane/wheelchair to get around inside or

outside the house

□ Do not need the help of another person or a special aid but have trouble getting

around freely

□ Not limited in any of these ways

21. Do you need help at **home because of health problems** and are unable to get help?

□ Yes □ No

22. Have you completed an Advance Directive/Living Will? □ Yes □ No

(A document that directs your health care wishes in the event you become ill)

22a. If Yes, is it on file with your PCP? □ Yes □ No

22b. If No, are you interested in receiving information on Advance Directive?

□ Yes □ No

23. Have you fallen in the last 12 months? □ Yes □ No

24. Do you have any wounds, sores or skin breakdown?

□ Yes □ No If Yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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25. Do you currently have any pain? If No, go to question 26.

□ Yes □ No If Yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

25a. Pain Severity Scale: 1-10, 10 being the most severe

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

25b. Do you take medicine for pain?

□ Yes □ No If Yes, name of medicine(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

25c. Does the pain medication provide adequate relief of your pain?

□ All the time □ Most of the time □ Some of the time □ None of the time

26. Do you feel depressed, angry, or lonely?

□ Yes □ No

26a. If Yes, are you currently being treated for depression?

□ Yes □ No

27. Do you feel you have a problem with:

Drug Abuse: □ Yes □ No

Do you drink alcohol? □ Daily □ Weekly □ Monthly / or \_\_\_\_ drinks per \_\_\_\_\_

How many times in the past year have you had 4 or 5 alcoholic drinks in a day? \_\_\_\_

28. Do you smoke? □ Yes □ No

28a. If Yes, are you interested in a Smoking Cessation Program? □ Yes □ No

29. Do you routinely get a flu shot every year? □ Yes □ No/Don’t know

30. Have you had a pneumonia shot in the past? □Yes No/Don’t know

31. Have you had a Zostavax shot in the past?( shingles vaccine) □ Yes □ No/Don’t know

32. Have you had a test to screen for colon cancer with one of the following?

FOBT (Fecal Occult Blood Test), testing the stool for presence of blood this year?

□ Yes □ No/Don’t know

DCBE(Double Contrast Barium Enema) X-Ray procedure any time last 4 years?

□ Yes □ No/Don’t know

Cologuard in the last 3 years?

□ Yes □ No/Don’t know

Flexible Sigmoidoscopy anytime in the last 4 years?

□ Yes □ No/Don’t know

Colonoscopy anytime in the last 10 years?

□ Yes □ No/Don’t know

33. Are you a caregiver? (for spouse or someone else)

□ Yes □ No

34. Is there a friend, relative or neighbor who would take care of you for a few days, if

necessary?

□ Yes □ No

If Yes, name, relationship, and day-phone of the person who could take care of you?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Phone Number

35. Is there anything else you would like us to know about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I understand that this information may be shared with my physician.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Today’s Date

**Thank you for your time in completing this questionnaire**