**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

Signature Today’s Date

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