Northeast Georgia DiagnosticClinic Since 1953 A Northside Network Provider

Medicare Annual Wellness Visit – Health Risk Assessment (HRA)

Patient Name:	Date of Birth:	Today's Date:

Please complete this Health Risk Assessment form and bring it with you to your scheduled Annual Wellness Visit appointment. Your answers will help ensure that you get the best possible care and allow us to develop your personalized care plan.

1. Are male or female?
   ☐Male ☐Female

2. What is your marital status?
   ☐Single
   ☐Married
   ☐Divorced
   ☐Widowed

3. What is your current living arrangement?
   ☐By myself
   ☐With spouse
   ☐With Family
   ☐Facility (assisted living, nursing home)
   ☐Other ___________________

4. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?
   ☐Not at all
   ☐Slightly
   ☐Moderately
   ☐Quite a bit
   ☐Extremely

5. During the **past four weeks,** has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
   ☐Not at all
   ☐Slightly
   ☐Moderately
   ☐Quite a bit
   ☐Extremely

6. Do you protect yourself from the sun when you are outdoors?
   ☐Yes ☐No

7. During the **past four weeks**, how much pain have you generally had each day (on a 1-10 scale)?
   ☐No pain - 0
   ☐Very mild pain -3
   ☐Mild pain - 5
   ☐Moderate pain -7
   ☐Severe pain – 10

8. Regarding your answer to question 7 above, how do you treat your pain (mark all that apply)?
   ☐Not applicable to me
   ☐Over the counter medication
   ☐Prescription medication
   ☐See a pain management physician

9. During the **past four weeks**, was someone available to help you if you needed/wanted help? *(For example, if you felt nervous, anxious, lonely; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help taking care of yourself.)*
   ☐Yes, as much as I wanted
   ☐Yes, quite a bit
   ☐Yes, some
   ☐Yes, a little
   ☐No, not at all

10. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?
    ☐Very heavy
    ☐Heavy
    ☐Moderate
    ☐Light
    ☐Very light

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11. Compared to last year, how would you rate your activity level?
    ☐Same as last year
    ☐More than last year
    ☐Less than last year

12. Can you get to places out of walking distance without help? *(For example, can you travel alone by driving, or by taking a bus or taxi?)*
    ☐Yes ☐No

13. Can you go shopping for groceries or clothes without someone's help?
    ☐Yes ☐No

14. Can you prepare your own meals?
    ☐Yes ☐No

15. Can you do your housework without help?
    ☐Yes ☐No

16. Because of any 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?
    ☐Yes ☐No

17. Are you able to manage your finances without help?
    ☐Yes ☐No

18. During the **past four weeks**, how would you rate your health in general?
    ☐Excellent
    ☐Very good
    ☐Good
    ☐Fair
    ☐Poor

19. How have things been going for you during the **past four weeks?**
    ☐Very well, could hardly be better
    ☐Pretty well
    ☐Good and bad parts about equal
    ☐Pretty bad
    ☐Very bad, could hardly be worse

20. Are you having difficulties driving your car?
    ☐Yes, often
    ☐Sometimes
    ☐No
    ☐Not applicable, I do not use a car

21. Do you always fasten your seatbelt when you are in a car?
    ☐Yes, always
    ☐Yes, somethings
    ☐No

22. How often during the **past four weeks** have you been ***bothered*** by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up					
Sexual problems					
Trouble eating well					
Teeth/Denture problems					
Problems using telephone					
Tiredness or fatigue					
Hearing Problems					
Vision Problems					

23. Have you fallen two or more times in the past year?
    ☐Yes ☐No

24. Are you afraid of falling?
    ☐Yes ☐No

25. Do you wear glasses/contact lenses?
    ☐No
    ☐Reading / Driving only
    ☐Daily use

26. Are you a smoker?
    ☐Current smoker
    ☐Former smoker
    ☐Never a smoker

27. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?
    ☐10 or more drinks per week
    ☐6-9 drinks per week
    ☐2-5 drinks per week
    ☐1 drink or less per week
    ☐No alcohol at all

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28. Do you exercise for about 20 minutes three or more days per week?
    ☐Yes, most of the time
    ☐Yes, some of the time
    ☐No, I usually do not exercise this much

29. Have you been given any information to help you with the following?
    a) Hazards in the house that might hurt you?
       ☐Yes ☐No
    b) Keeping track of your medications?
       ☐Yes ☐No

30. How often do you have trouble taking medicines the way you have been told to take them?
    ☐I do not have to take medicine
    ☐I always take them as prescribed
    ☐Sometimes I take them as prescribed
    ☐I seldom take them as prescribed

31. How confident are you that you can control and manage most of your health problems?
    ☐Very confident
    ☐Somewhat confident
    ☐Not very confident
    ☐I do not have any health problems

32. Do you use illegal drugs or legal drugs in an illegal manner?
    ☐Yes ☐No

33. Do you have a living will or advanced directive?
    ☐Yes, I have one in place
    ☐No, I do not have one in place
    ☐I would like more information on this

34. Over the **past 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				
Trouble falling asleep, staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you're a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead or of hurting yourself in some way				

If you checked any problems in question 34 above, how difficult have those problems made 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

35. In the past week, how many servings of:
    a) Fruits and vegetables ______servings per day
    b) High fiber and whole grains (whole wheat bread, whole grain high fiber cereal, oatmeal, brown rice or whole wheat pasta) ______servings per day
    c) Fried or high fat foods (fried fish or chicken, bacon, French fries, chips, doughnuts, creamy dressings, and food made with whole milk, cream, cheese or mayonnaise) ______servings per day
    d) Sugar sweetened (not diet) beverages ______servings per day
    e) Dessert ______servings per day

Please list all allergies (and reactions, if known)

Have you had any recent surgeries, hospitalizations, or visits to the Emergency Room? If yes, please list date and reason/type.

Family Medical History

For each of the medical conditions noted below, please indicate in the appropriate box any family member that has a history of the condition.	Mother	Father	Children	Siblings	Grandparents
Hypertension (high blood pressure)					
Heart disease					
Stroke / TIA					
Diabetes					
High cholesterol					
Dementia					
Depression					
Cancer					

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Please list all physicians or healthcare providers that you have seen in the last 12 months. (Example: Dr. Smith – Neurologist, Dr. Jones – Eye Doctor)	
Primary Care Physician	
Eye Doctor	
Cardiologist (heart)	
Gynecologist	
Pain Management Physician	
Endocrinologist (diabetes, thyroid)	

Please list any companies that provide you with medical equipment or services. (Example: oxygen, CPAP machines, home health agency)
Please list the name and location of any pharmacies that you currently use.

Please bring all of your medicines to your visit, or fully complete the following section. Be sure to include any over-the counter drugs, vitamins, and herbal supplements.	
Medication	Dosage

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REVIEW OF SYSTEMS (Please verify if you have had any of the following within the last 30 days)
Please circle Yes or No and explain yes answers.

GENERAL			
Fatigue, tiredness	YES	NO	____________________
Increased thirst or urination	YES	NO	____________________
Fever or chills	YES	NO	____________________
Any new lumps/bumps on the body	YES	NO	____________________
Unexplained weight loss	YES	NO	____________________
Unexplained weight gain	YES	NO	____________________
Night sweats	YES	NO	____________________
Difficulty with sleep	YES	NO	____________________
EYES			
Changed vision	YES	NO	____________________
Red eye(s)	YES	NO	____________________
Dry eye(s)	YES	NO	____________________
Painful eye(s)	YES	NO	____________________
Spots/wavy lines	YES	NO	____________________
Flashes with eye movement	YES	NO	____________________
Flickering lights	YES	NO	____________________
Do you wear contacts	YES	NO	____________________
EARS, NOSE, AND THROAT			
Bleeding from the nose	YES	NO	____________________
Snoring	YES	NO	____________________
Recurring sinus infections	YES	NO	____________________
Bothersome nasal allergies	YES	NO	____________________
Trouble breathing through your nose	YES	NO	____________________
Problems with taste or smell	YES	NO	____________________
Ringing in the ears	YES	NO	____________________
PSYCHIARTIC			
Anxiety	YES	NO	____________________
Depression	YES	NO	____________________
Thoughts of hurting yourself	YES	NO	____________________
Thoughts of hurting others	YES	NO	____________________
MIUSCULOSKELETAL			
Neck pain	YES	NO	____________________
Back pain	YES	NO	____________________
Joint pain	YES	NO	____________________
Redness of swelling of any joints	YES	NO	____________________
URINARY			
Pain with urination	YES	NO	____________________
Blood in urine	YES	NO	____________________
Urinating too frequently	YES	NO	____________________
Trouble with ease of urinary flow	YES	NO	____________________
SKIN			
New moles	YES	NO	____________________
New rash	YES	NO	____________________
Psoriasis	YES	NO	____________________
Persistent itching	YES	NO	____________________
Sores/open wounds	YES	NO	____________________
CV			
Chest Pain	YES	NO	____________________
Episode of rapid or irregular heartbeat	YES	NO	____________________
Swelling in legs/feet	YES	NO	____________________
Awakening at night because of shortness of breath	YES	NO	____________________

RESPIRATORY			
Shortness of breath	YES	NO	________________
Wheezing	YES	NO	________________
Cough	YES	NO	________________
Coughing up blood	YES	NO	________________
Have you been told you stop breathing in your sleep	YES	NO	________________
GI			
Abdominal pain	YES	NO	________________
Difficulty with swallowing	YES	NO	________________
Pain with swallowing	YES	NO	________________
Black stool	YES	NO	________________
Blood in your stool	YES	NO	________________
Constipation	YES	NO	________________
Diarrhea	YES	NO	________________
Vomiting	YES	NO	________________
Nausea	YES	NO	________________
Heartburn/Acid Reflux	YES	NO	________________
NEUROLOGIC			
Headaches	YES	NO	________________
Fainting spells	YES	NO	________________
Episodes of seizures	YES	NO	________________
Vertigo/Room spinning	YES	NO	________________
Frequent falling	YES	NO	________________
HEMATOLOGIC			
Abnormal bruising	YES	NO	________________
Abnormal bleeding	YES	NO	________________
Recurrent blood clots	YES	NO	________________
FEMALE			
Abnormal periods	YES	NO	________________
Vaginal discharge	YES	NO	________________
Post-menopausal/Hysterectomy	YES	NO	________________
Currently on birth control pills	YES	NO	________________
Currently on hormone therapy	YES	NO	________________
Breast lump/Nipple discharge	YES	NO	________________
MALE	YES	NO	________________
Penis discharge	YES	NO	________________
Testicular pain/Testicular lump	YES	NO	________________
Prostate problem	YES	NO	________________
Hernia (rupture)	YES	NO	________________
Sexual difficulty/Impotence	Yes	NO	________________

OTHER SYMPTOMS:

____

____

____

____

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months...		**Circle**	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		**Score:**	

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Drug Abuse Screening Test (DAST-10). (Copyright 1982 by the Addiction Research Foundation.)