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Medicare Annual Health Risk Assessment

Today's Date: _____________

Patient Name: ____ **Date of Birth:** ________________

Address: ____

Email Address: ____

Home Phone Number: ______________________________ **Mobile Number:** ______________________

Preferred Contact: ☐ Cell Phone ☐ Home Phone ☐ Mail ☐ Portal

What sex was originally listed on your birth certificate?
☐ Female ☐ Male ☐ decline to answer

Do you think of yourself as: ☐ Female ☐ Male ☐ Trans-male to female ☐ Trans-female to male
☐ Non-binary ☐ Other_________________ ☐ decline to answer

Preferred Gender Pronoun: ___________

Sexual Preference: ☐ Straight/heterosexual ☐ Lesbian/gay/homosexual ☐ bisexual
☐ other: ______________________ ☐ decline to answer

Race: ☐ White ☐ Black/African American ☐ Asian
☐ Native Hawaiian/other Pacific Islander ☐ All other ☐ Decline to specify

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Primary language: _________________________

What is your highest grade or level of school that you completed?
☐ 8th grade or less ☐ Some high school
☐ High school graduate or GED ☐ Some college or 2-year degree
☐ 4-year college graduate ☐ More than a 4 year college degree

1. What are your health care or lifestyle goals for the next year?
☐ Quit smoking ☐ Quit or cut down on alcohol ☐ Increase exercise ☐ Eat healthier
☐ Reduce Stress ☐ Lose weight ☐ Continue working ☐ Return to work
☐ Maintain current lifestyle/living arrangements

2. In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

3. Do you feel your health is better or worse than it was six months ago? ☐ Better ☐ Worse ☐ Same

4. Is your hearing ☐ good ☐ good with hearing aids ☐ fair ☐ poor

5. Is your vision ☐ good ☐ good with glasses ☐ fair ☐ poor

6. Without wanting to, have you lost or gained 10 pounds in the last 6 months? ☐ Yes ☐ No

7. In the past 7 days, how many days did you exercise for 30 minutes or more?
☐ 0 ☐ 1 - 2 ☐ 3 - 5 ☐ 6 - 7

Name________________________________**Date of birth**____________________**Date**______________

8. Do you have any difficulty with sleep? ☐ Yes ☐ No

9. Do you have any difficulty with leaking urine? ☐ Yes ☐ No

10. In the past 7 days, how much did pain interfere with your day to day activities?
☐ Not at all ☐ A little bit ☐ Quite a bit ☐ Very much

11. How many times have you stayed overnight as a patient in a hospital in the past 6 months? ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

12. How many times did you go to the Emergency room in the past 3 months? ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

13. In the last 30 days, did you stay overnight in a hospital and then have another stay in a hospital? ☐ 0 ☐ 1 or more

14. Have you seen an eye doctor in the last year? ☐ Yes ☐ No

15. Have you seen a dentist in the last year? ☐ Yes ☐ No

16. Please list any specialists you see: ____

____

17. How many prescription medications do you take on a regular basis? ☐ 0-8 ☐ 9-12 ☐ 13 or more

18. Do you ever have a hard time affording your medications? ☐ Yes ☐ No

19. How often do you have difficulty remembering to take your medications?
☐ Never/rarely ☐ Once in awhile ☐ Sometimes ☐ Usually ☐ All the time

Functional Assessment/Home Environment

20. Did you fall in the past year? ☐ Yes ☐ No
How many times? _______
Were you injured? ☐ Yes ☐ No ☐ No falls

21. Do you worry about falling? ☐ Yes ☐ No

22. Do you have stairs leading to or in your home? ☐ Yes ☐ No ☐ Not applicable

23. Do you have any of the following safety measures in your home?
☐ Smoke Detector ☐ Carbon Monoxide detector ☐ Safety bars in bathroom ☐ Night lights

24. Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person? (Check all that apply)
☐ None ☐ Climbing stairs
☐ Getting in or out of chairs ☐ Eating
☐ Walking ☐ Using the toilet
☐ Dressing and grooming ☐ Bathing
☐ Control over urination and bowel movements

25. Because of a health or physical problem, do you have any difficulty doing the following activities? (Check all that apply)
☐ None ☐ Preparing meals
☐ Managing money ☐ Shopping
☐ Doing housework ☐ Doing laundry
☐ Taking medication as prescribed
☐ Using the phone and looking up numbers
☐ Driving or using public transportation

Name____________________________________ **Date of birth**______________________ **Date**________________

26. Do you use any of the following assistive devices? (Check all that apply)
☐ Cane ☐ Walker
☐ Shower bar/seat ☐ Wheelchair
☐ Hoyer lift ☐ Hospital Bed
☐ None of these ☐ Other:

27. Are you currently receiving any of the following services from an agency? (Check all that apply)
☐ Visiting Nurse ☐ Occupational Therapy
☐ Physical Therapy ☐ Speech Therapy
☐ Transportation Service ☐ Homemaker/Chore Service
☐ Social Worker ☐ Adult Day Center
☐ Home Health Aide ☐ Home Delivered Meals
☐ Tele-monitoring Program ☐ None of these

28. Do you use supplemental oxygen? ☐ Yes ☐ No

Mood Assessment

29. PHQ2-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	Declined to specify
1. Little interest or pleasure in doing things	☐	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐	☐

30. Have you experienced a significant loss or stressful event such as a death, move or job loss in the last year?
☐ No ☐ Yes ____

31. Do you have trouble remembering or recalling facts? ☐ Yes ☐ No

32. Do family members or care-givers report that you have difficulty remembering things? ☐ Yes ☐ No

33.In the last two weeks, have you been bothered by any of the following problems? Feeling nervous, anxious or on edge or not been able to stop or control your worrying ☐ Yes ☐ No

Health Literacy

34. In general, how well do you feel you understand your medical conditions and who to call if you have a problem?
☐ Very well ☐ Somewhat ☐ Not at all
☐ Decline to answer

35. How confident are you filling out medical forms by yourself?
☐ Extremely ☐ Quite a bit ☐ Somewhat
☐ Not at all

36. Do you need assistance with scheduling a medical appointment or understanding your health insurance benefits? ☐ Yes ☐ No

Social History

37. How often do you use nicotine (tobacco) products? ☐ Every day ☐ Some days ☐ Not at all
Do you Vape? ☐ Every day ☐ Some days ☐ Not at all
38. Are you interested in quitting the above? ☐ Yes ☐ No ☐ Not applicable

39. In the past week, on how many days did you drink alcohol? ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ I don't drink alcohol

40. On days when you drink alcohol, how much do you normally drink? ______________

41. During the last 12 months, have you used alcohol or drugs in ways that cause problems for you or those around you? ☐ Yes ☐ No

Name____________________ **Date of birth**________________ **Date**__________

Social Determinants of Health

42. Do you have enough food to eat? ☐ Yes ☐ No

43. Do you have a steady place to live? ☐ Yes ☐ No

44. Do you know what to do in case there is a fire? ☐ Yes ☐ No

45. Do you have a plan in case there is a natural disaster (i.e. snowstorm, flood, etc) ☐ Yes ☐ No

46. Who do you live with? ☐ Alone ☐ With spouse ☐ With a son or daughter ☐ With other family member ☐ With non-relative

47. Are you responsible for providing care-giving assistance to someone else? ☐ Yes ☐ No

48. Do you have care-givers or family members who regularly help in your care? ☐ Yes ☐ No

49. Do you have a friend, relative or neighbor who can take care of you for a few days, if necessary? ☐ Yes ☐ No

50. Do you have trouble getting to places where you need to go? ☐ Yes ☐ No

51. Can you afford to pay your bills(utilities, food, transportation, housing, etc) ☐ Yes ☐ No

52. How often does anyone, including family and friends…

Threaten you with harm? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently

Physically hurt you? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently

53. How often do you feel lonely or isolated from those around you? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

54. Do you participate in any activities such as: ☐ Religious Services ☐ Volunteering ☐ Clubs/Civic Org. ☐ Hobbies

55. Anyone having sexual contacts or sharing drug needles or equipment may be at risk for HIV/AIDS. Other contact with blood or body fluids may also pose a risk. NYS recommends testing for everyone over age 13 at least once and more often if at increased risk. ☐ I decline testing ☐ I would like to be tested ☐ I would like to discuss

Goals and Advanced Care Planning

56.

Have you signed any of the following legal documents?

☐ Medical Power of Attorney ☐ Health Care Proxy
☐ Financial Power of Attorney ☐ Living Will
☐ Do Not Resuscitate Order (DNR)
☐ POLST/MOLST (Physicians/Medical Order for Life-Sustaining Treatment)

57. Have you had a discussion with your family about your end of life wishes? ☐ Yes ☐ No

Patient Name: ______________________________ Date of Birth:___________Date visit: _________

Please check any symptoms or problems you are having (or none):

General:
☐ fever
☐ night sweats
☐ unexplained weight loss or gain
☐ fatigue
☐ none

Skin:
☐ rashes
☐ itching
☐ changes in hair, skin or nails
☐ none

Ear, Eyes, Nose, Throat:
☐ ear pain
☐ change in hearing
☐ eye problems
☐ persistent runny nose
☐ sore throat
☐ change in voice
☐ sinus trouble
☐ none

Gastrointestinal:
☐ nausea,vomiting
☐ blood in stool
☐ ulcers
☐ change in bowel movements
☐ heartburn
☐ abdominal pain
☐ none

Heart:
☐ chest pain
☐ swelling in ankles
☐ palpitations, racing heart
☐ none

Lungs:
☐ cough
☐ shortness of breath
☐ wheezing
☐ none

Genital/Urinary:
☐ blood in urine
☐ pain with urination
☐ loss of urine control
☐ none

Women:
☐ vaginal discharge
☐ change in menstrual cycle or sexual function
☐ None

Men:
☐ testicular pain
☐ penile discharge
☐ decreased urinary stream
☐ Change in sexual function
☐ None

Orthopedic:
☐ painful or swollen joints
☐ muscle weakness
☐ none

Neuro/psych:
☐ tremor
☐ frequent headaches
☐ depression
☐ anxiety
☐ none

Please list any other concerns:

Patient Signature:____Date: _______________

Name of Person Completing the HRA (if not self): ____
Relationship: ____

Provider Signature: ____