Medicare Annual Wellness Visit
Health Risk Assessment Questionnaire

This questionnaire is required for all First and Subsequent Annual Wellness Visits (AWV) and is used for Welcome to Medicare Visits (also called Medicare Initial Preventive Physical Exam or IPPE).

If you have completed this questionnaire electronically through eCare, please let the front desk know

TODAY'S DATE: ____/____/_____

NAME: Last _____ First _____ MI _____ BIRTHDATE: __/__/____

Your answers to all the following questions will help the provider identify your preventive care needs and possible health risks, and allow more time for discussion during the visit.

CARE PROVIDERS:

Please list care providers who are outside UW Medicine (including specialists, eye doctor, naturopaths, etc.):

_____

_____

SELF ASSESSMENT OF HEALTH:

Please check one response for each question:

1) How do you rate your overall health the past 4 weeks? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2) Can you manage your overall health problems? ☐ Yes ☐ No

3) 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

4) Do you often get the emotional support you need? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

PSYCHOSOCIAL HEALTH:

Please check one response for each question:

In the past 2 weeks, how often have you been bothered by the following:

5) Feelings that caused you distress or interfered with your ability to get along socially with family or friends?	Not at all	Several days	More than half the days	Nearly every day
6) Feeling stress over health, finances, relationships or work?	Not at all	Several days	More than half the days	Nearly every day
7) Body pain?	Not at all	Several days	More than half the days	Nearly every day
8) Fatigue?	Not at all	Several days	More than half the days	Nearly every day

HEALTH AND HABITS:

Unless otherwise noted, please check one response for each question:

9) In the past 7 days, how many days did you exercise?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

10) On days when you exercised, for how long did you exercise (in minutes)?
☐ _____minutes (please provide estimate of minutes, 0-120+)
☐ Does not apply

11) How intense was your typical exercise?
☐ Light (like stretching or slow walking)
☐ Moderate (like a brisk walk)
☐ Heavy (like jogging or swimming)
☐ Very heavy (like fast running or stair climbing)
☐ I am currently not exercising

12) In the past 7 days, how often did you eat 3 or more servings of fruits and vegetables in a day?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

13) In the past 7 days, how often did you eat 3 or more servings of high fiber or whole grain foods in a day?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

14) How would you describe the condition of your mouth and teeth, including false teeth or dentures?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

15) Do you find yourself having trouble hearing people speak? ☐ Yes ☐ No

16) Do you wear a hearing aid/device? ☐ Yes ☐ No

17) Do you always use your seat belt in the car? ☐ Yes ☐ No

18) Do you have a fire extinguisher in your home? ☐ Yes ☐ No

19) Do you have a smoke detector? ☐ Yes ☐ No

FUNCTION AND MOBILITY

Unless otherwise noted, please check one response for each question:

In your present state of health, how much difficulty do you have with the following activities?

20) Preparing food and eating	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
21) Bathing yourself	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
22) Getting dressed	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
23) Using the toilet	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
24) Moving around from place to place	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me

25) Please check any aids or devices that you usually use for any of the above activities (check all that apply):

☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Special or built up chair
☐ Built up or special utensils ☐ Devices used for dressing (button hook, zipper pull, etc.)
☐ None of the above

26) In the past year have you fallen or had a near fall? ☐ Yes ☐ No

27) Are you afraid of falling? ☐ Yes ☐ No

28) Do you have issues with balance or feeling unsteady? ☐ Yes ☐ No

29) Do you feel safe in your home environment? ☐ Yes ☐ No

30) Is there anything in your home that might make you trip or slip, and fall? ☐ Yes ☐ No

31) Do you ever leak urine or stool? ☐ Yes ☐ No

32) Do you wear a liner, pad, or special underwear because of leakage? ☐ Yes ☐ No

In your present state of health, how much difficulty do you have with the following activities?

33) Shopping	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
34) Using the telephone	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
35) Housekeeping	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
36) Laundry	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
37) Driving or using transportation	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
38) Managing your own finances	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
39) Taking your own medications	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me

SIGNS OF MEMORY ISSUES

Please check one response for each question:

40) Have you experienced any memory issues or problems with thinking? ☐ Yes ☐ No

41) Have any concerns about your memory been raised by family members, friends, caretakers, or others?

☐ Yes ☐ No

SCREENING AND PREVENTIVE SERVICES

Your provider will review with you which if these screening and prevention measures are specifically recommended for you. Our records show which of these have previously been done within UW Medicine. **Please answer this section if you have had any of the following screening or preventive measures done <u>outside of UW Medicine</u> most recently**:

Screening / Test	**Please let us know where and when this was most recently done, IF it was last done outside of UW Medicine:**
Pneumococcal vaccines (e.g. Prevnar, Pneumovax)	Where completed:_____ When completed:_____
Influenza Vaccine	Where completed:_____ When completed:_____
Hepatitis B Vaccine	Where completed:_____ When completed:_____
Mammogram Screening (Women)	Where completed:_____ When completed:_____ Results normal? ☐ Yes ☐ No ☐ Unsure
Pap Smear (Women)	Where completed:_____ When completed:_____ Results normal? ☐ Yes ☐ No ☐ Unsure
Colorectal Cancer Screening	Where completed:_____ When completed:_____ Results normal? ☐ Yes ☐ No ☐ Unsure
Diabetes screening (e.g. glucose or blood sugar testing)	Where completed:_____ When completed:_____ Results normal? ☐ Yes ☐ No ☐ Unsure
Cholesterol panel	Where completed:_____ When completed:_____ Results normal? ☐ Yes ☐ No ☐ Unsure
Bone Density Screening	Where completed:_____ When completed:_____ Results normal? ☐ Yes ☐ No ☐ Unsure
Eye exam	Where completed:_____ When completed:_____ Results normal? ☐ Yes ☐ No ☐ Unsure

Abdominal Aortic Aneurysm Screening	Where completed:_____ When completed:_____ Results normal? ☐ Yes ☐ No ☐ Unsure

ADVANCED CARE PLANNING

Please check one response for each question:

Do you currently have this in place?			
42) POLST form (Physician orders for life-sustaining treatment)	☐ Yes	☐ No	☐ Don't know / don't remember
43) Living will (documents that make your health care wishes know, also called Advance Directive)	☐ Yes	☐ No	☐ Don't know / don't remember
44) Durable Power of Attorney for Medical Affairs (someone to make medical decisions for you in the event that you are unable to)	☐ Yes	☐ No	☐ Don't know / don't remember

45) Do you want to discuss advance care planning at your wellness visit?
☐ Yes ☐ No ☐ Not sure

PROVIDER SIGNATURE	PRINT NAME	PAGER	NPI	DATE	TIME

PLACE PATIENT LABEL HERE