Medicare Health Risk Assessment (HRA)
For Annual Wellness Visits

Patient Name ____ **Today's Date** ________________

Race /Ethnicity________________ **Sex** __________________ **Date of Birth** __________________

PHYSICAL ACTIVITY/ EXERCISE

How many days a week do you usually exercise?

____________ days per week __________ amount of time spent exercising

How intense is your typical exercise?

☐ Light (stretching or slow walking) ☐ Moderate (brisk walking) ☐ Heavy (jogging or swimming)

☐ Very heavy (running or stair climbing) ☐ I am currently not exercising

SMOKING/TOBACCO USE

Do you currently smoke cigarettes or use other types of tobacco?

☐ Current Everyday ☐ Current Somedays ☐ Former Smoker ☐ Never a Smoker

ALCOHOL USE

In a typical week, how often do you have 1 or more alcoholic drinks on one occasion?

☐ No alcohol use

☐ Social drinker

☐ Moderate (Men: 2 per day or less; Women: 1 per day or less)

☐ Alcohol use (3 or more per day)

NUTRITION Do you eat fiber, fruits and vegetables? ☐ Yes ☐ No

ORAL HEALTH Do you see a dentist yearly? ☐ Yes ☐ No

HEARING

Do you have difficulty hearing when someone speaks in a whisper? ☐ Yes ☐ No

Do you have hearing problems when in a crowd? ☐ Yes ☐ No

Does a hearing problem cause you to argue with family members? ☐ Yes ☐ No

SLEEP How many hours of sleep do you get each night? ________________

ACTIVITIES OF DAILY LIVING

Do you feel that you need assistance with dressing, feeding or bathing? ☐ Yes ☐ No

Do you have feelings of unsteadiness including balance? ☐ Yes ☐ No

Do you need help with your medications? ☐ Yes ☐ No

Do you need assistance with handling financial affairs? ☐ Yes ☐ No

How many times have you fallen in the past year? _______ times

Do you need assistance with shopping, food preparation, housekeeping, laundry or transportation?

☐ Yes ☐ No

MOTOR VEHICLE SAFETY

Do you wear a seatbelt every time you are in an automobile? ☐ Yes ☐ No

SUN EXPOSURE When outdoors, do you wear sunscreen? ☐ Yes ☐ No

HOME SAFETY Do you have working smoke and fire detectors in your home ☐ Yes ☐ No

HIGH STRESS

How well do you handle the stress in your life? ☐ I'm usually able to cope effectively

☐ At times I have problems coping

☐ I often have problems coping

How often is stress a problem for you? ☐ Never/Rarely ☐ Sometimes ☐ Often ☐ Always

GENERAL WELL-BEING

In general, would you say your health is? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

DEPRESSION

Have you felt little interest or pleasure in doing things? ☐ Yes ☐ No

Have you felt sad, depressed, or helpless? ☐ Yes ☐ No

Have your feelings caused you distress or interfered with your ability to interact socially with friends?

_______ Yes _______ No

Generally, how satisfied are you with your life?

☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

SOCIAL/EMOTIONAL SUPPORT

How often do you get the social and emotional support you need:

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Patient Name ______________________ Date of Birth __________