Medicare Annual Wellness Visit Basic Health Risk Assessment

Name__________________________________ **DOB**_______________ **Today's Date**_______________

1. How is your general health?

Excellent	Very good	Good	Fair	Poor

2. Do you need assistance with daily activities?

Dressing/ Bathing	Walking	Phone	Transport	Shopping
Meal Prep	House Chores	Meds	Finances	Other

3. Do you have a caregiver helping you at home?

Family Member	Paid caregiver	Other	None

4. Do you feel your home environment is safe?

Yes	No

5. Are you having memory issues or are family members concerned about your memory?

Yes	No

6. Do you exercise? How many times a week?

Yes	No	______

7. Have you had problems with bladder control?

Yes	No

8. Do you have issues with your hearing?

Yes	No

9. Do you have issues with anxiety/depression?

Yes	No

10. Can you afford your medications?

Yes	No

11. Do you have an advanced directive/living will?

Yes	No

12. Have you used opioid containing pain meds in last 6 months?

Yes	No

13. Have you had any falls in the past year?

Yes	No

14. How is your balance?

Very good	Fair	Poor

Please list other providers you see.