

Alamo Hills Medical Group, INC.
MEDICARE ANNUAL WELLNESS HEALTH RISK ASSESSMENT,
FUNCTION SCREEN AND MEDICATION LIST

Patient's Name _____ D.O.B. _____ Date _____

1. BEHAVIORAL RISK FACTORS

PHYSICAL INACTIVITY/LACK OF EXERCISE

How many days a week do you exercise? _____
On days that you exercise, for how long do you usually exercise? _____
How intense is your typical exercise?
____ Light (stretching or slow walking)
____ Moderate (brisk walking)
____ Heavy (jogging or swimming)
____ Very Heavy (fast running or stair climbing)
____ I am currently not exercising

SMOKING/TOBACCO USE

Do you currently smoke cigarettes or use other types of tobacco? _____
Are you a former smoker?
____ Yes, and I quit
____ No, I've never smoked
____ Does not apply
If you quit smoking, how long ago did you quit smoking cigarettes?
____ Less than 6 months ago
____ 6-11 months ago
____ 1-5 years ago
____ 6-10 years ago
____ More than 10 years ago
____ Does not apply
Do you use other tobacco products?
____ Cigars
____ Pipes
____ Chewing tobacco/Snuff
____ I use no other tobacco products

ALCOHOL/DRUG USE

In a typical week, how many days do you drink? _____ days per week
On days that you drink alcohol, how many drinks do you consume? _____ drinks per day
In a typical week, how often do you have 5 or more alcoholic drinks on one occasion?
____ Never
____ Once per week
____ 2-3 times per week
____ More than 3 times per week
Do you use recreational Drugs? _____

MOTOR VEHICLE SAFETY

Do you always fasten your seat belt? _____
Do you ever drive after drinking, or ride with a driver who has been drinking? _____

SUN EXPOSURE

Do you protect yourself from the sun when you are outdoors? _____

NUTRITION

On a typical day, how many servings of fruit and/or vegetables do you eat? _____ servings per day
(1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit,
1 cup = size of baseball)

On a typical, how many servings of high fiber or whole grain foods do you eat? _____ servings per day
(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½
cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole-wheat pasta)

On a typical day, how many servings of fried or high-fat foods do you eat? _____ servings per day
(Examples include fried chicken, fried fish, bacon, French fries, potato chips, doughnuts, salad dressing and foods made with
whole milk, cream, cheese or mayonnaise)

2. PSYCHOSOCIAL RISK FACTORS

GENERAL WELL-BEING

In general, would you say your health is?

- _____ Excellent
- _____ Very Good
- _____ Good
- _____ Fair
- _____ Poor

DEPRESSION

Over the past 2 weeks, how often have you felt down, depressed or hopeless?

- _____ Almost all the time
- _____ Most of the time
- _____ Some of the time
- _____ Almost never

Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?

- _____ Almost all the time
- _____ Most of the time
- _____ Some of the time
- _____ Almost never

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

During the past 6 months, how often have you felt sad or depressed?

- _____ Almost all the time
- _____ Most of the time
- _____ Some of the time
- _____ Almost never

In general, 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

HIGH STRESS

How often is stress a problem for you?

- _____ Never/rarely
- _____ Sometimes
- _____ Often
- _____ Always

How well do you handle stress in your life?

- _____ I'm usually able to cope effectively
- _____ At times I have problems coping
- _____ I often have problems coping

SLEEP

How many hours of sleep do you get each night? _____ hours per night

3. FUNCTION SCREEN

DAILY LIVING

Do you need help with preparing meals, transportation, shopping, taking your medicine, managing your finances or other daily living? _____

Do you live alone? _____

HOME SAFETY

Does your home have throw rugs, poor lighting or slippery bathtub/showers? _____

Does your home LACK grab bars in bathrooms or handrails on stairs and steps? _____

Does your home LACK functioning smoke alarms? _____

HEARING LOSS

Do you have trouble hearing the television or radio when others do not? _____

Do you have to strain or struggle to hear/understand conversations? _____

VISION LOSS

Do you have trouble reading the print of newspapers or books? _____ if so, do you wear glasses/contacts? _____

Do you strain or struggle to put things into focus? _____ if so, do you wear glasses/contacts? _____

