Health Risk Assessment -Large Type

This form is available at: www.mainehealth.org/AWV

Medicare Annual Wellness Checkup

Your name:_____

Today's date:_____

Your date of birth: _____

Please fill out this form before seeing your doctor or nurse. Your answers will help you get the best possible health care.

1. What is your age?

☐ 65 - 69 ☐ 70 - 79 ☐ 80 or older

2. Are you a male or a female?

☐ Male ☐ Female

3. During the **past four weeks**, how much have you been bothered by feeling anxious, depressed, irritable, sad, or downhearted and blue?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

4. During the **past four weeks**, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

- ☐ Not at all.
- ☐ Slightly.
- ☐ Moderately.
- ☐ Quite a bit.
- ☐ Extremely.

5. During the **past four weeks**, how much bodily pain have you generally had?

- ☐ No pain.
- ☐ Very mild pain.
- ☐ Mild pain.
- ☐ Moderate pain.
- ☐ Severe pain.

6. During the **past four weeks**, was someone available to help you if you needed and wanted help?

(For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with your daily chores; or needed help just taking care of yourself.)

- ☐ Yes, as much as I wanted.
- ☐ Yes, quite a bit
- ☐ Yes, some.
- ☐ Yes, a little.
- ☐ No, not at all.

7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

- ☐ Very heavy.
- ☐ Heavy.
- ☐ Moderate.
- ☐ Light.
- ☐ Very light.

8. Can you get to places that are farther than walking distance without help?

(For example, can you travel alone or on buses or taxis, or drive your own car?)

☐ Yes ☐ No

9. Can you go shopping for groceries or clothes without someone's help?

☐ Yes ☐ No

10. Can you prepare your own meals?

☐ Yes ☐ No

11. Can you do your housework without help?

☐ Yes ☐ No

12. 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

13. Can you handle your own money without help?

☐ Yes ☐ No

14. During the **past four weeks**, how would you rate your health in general?

- ☐ Excellent.
- ☐ Very good.
- ☐ Good.
- ☐ Fair.
- ☐ Poor.

15. How have things been going for you during the **past four weeks**?

- ☐ Very well; could hardly be better
- ☐ Pretty well.
- ☐ Good and bad parts about equal.
- ☐ Pretty bad.
- ☐ Very bad; could hardly be worse.

16. Are you having difficulties driving your car?

- ☐ Yes, often.
- ☐ Sometimes.
- ☐ No.
- ☐ I do not use a car.

17. Do you always fasten your seat belt when you are in a car?

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

18. How often during the **past four weeks** have you been bothered by any of the following problems?

Falling or dizzy when standing up.

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Sexual problems.

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Trouble eating well.

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Teeth or denture problems.

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Problems using the telephone.

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Tiredness or fatigue.

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

19. Have you fallen two or more times in **the past year**?

☐ Yes ☐ No

20. Are you afraid of falling?

☐ Yes ☐ No

21. Are you a smoker?

- ☐ No.
- ☐ Yes, and I might quit.
- ☐ Yes, but I'm not ready to quit.

22. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- ☐ 10 or more drinks per week.
- ☐ 6 – 9 drinks per week.
- ☐ 2 – 5 drinks per week.
- ☐ One drink or less per week.
- ☐ No alcohol at all.

23. Do you exercise for about 20 minutes three or more days a week?

- ☐ Yes, most of the time.
- ☐ Yes, some of the time.
- ☐ No, I usually do not exercise this much.

24. Have you been given any information to help you with the following:

Hazards in the house that might hurt you?

☐ Yes ☐ No

Keeping track of your medications?

☐ Yes ☐ No

25. How often do you have trouble taking medications the way you have been told to take them?

- ☐ I do not have to take medicine.
- ☐ I always take them as prescribed.
- ☐ Sometimes I take them as prescribed.
- ☐ I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident.
- ☐ Somewhat confident.
- ☐ Not very confident.
- ☐ I do not have any health problems.

27. What is your race?

- ☐ White.
- ☐ Black or African American.
- ☐ Asian.
- ☐ Native Hawaiian or other Pacific Islander.
- ☐ American Indian or Alaskan Native.
- ☐ Hispanic or Latino origin or descent.
- ☐ Other.

Thank you very much for completing you Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

The contents of this Medicare Wellness Checkup is adapted from http://www.HowsYourHealth.org.
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