Medicare Wellness Visit Health Risk Assessment

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 MyChart, 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:

1) Over the past 4 weeks, how do you rate your overall health?
   □ Excellent   □ Good   □ Fair   □ Poor

PSYCHOSOCIAL HEALTH:

Please select one response for each question:

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

<table>
<thead>
<tr>
<th></th>
<th>Feeling stress over health, finances, relationships or work?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Body pain?</td>
<td>Not at all</td>
<td>Several days</td>
<td>More than half the days</td>
<td>Nearly every day</td>
</tr>
<tr>
<td>3</td>
<td>Feeling anger?</td>
<td>Not at all</td>
<td>Several days</td>
<td>More than half the days</td>
<td>Nearly every day</td>
</tr>
</tbody>
</table>
HEALTH AND HABITS:

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

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

6) 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

7) How do you rate your nutrition?
   - □ Excellent
   - □ Good
   - □ Fair
   - □ Poor

8) How would you describe the condition of your mouth and teeth, including false teeth or dentures?
   - □ Excellent
   - □ Good
   - □ Fair
   - □ Poor

9) Do you find yourself having trouble hearing people speak?  □ Yes  □ No

10) Do you always use your seat belt in the car?  □ Yes  □ No

11) Do you have a fire extinguisher in your home?  □ Yes  □ No

12) Do you have a smoke detector?  □ Yes  □ No

FUNCTION AND MOBILITY

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

How much difficulty do you have with the following activities?

<table>
<thead>
<tr>
<th></th>
<th>Preparing food and eating</th>
<th>Bathing yourself</th>
</tr>
</thead>
<tbody>
<tr>
<td>13)</td>
<td>□ I can do this by myself</td>
<td>□ I can do this by myself</td>
</tr>
<tr>
<td></td>
<td>□ I need some help to do it</td>
<td>□ I need some help to do it</td>
</tr>
<tr>
<td></td>
<td>□ I cannot do this; another person needs to do it for me</td>
<td>□ I cannot do this; another person needs to do it for me</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>15) Getting dressed</td>
<td>I can do this by myself</td>
<td>I need some help to do it</td>
</tr>
<tr>
<td>16) Using the toilet</td>
<td>I can do this by myself</td>
<td>I need some help to do it</td>
</tr>
<tr>
<td>17) Moving around from place to place</td>
<td>I can do this by myself</td>
<td>I need some help to do it</td>
</tr>
<tr>
<td>18) Shopping</td>
<td>I can do this by myself</td>
<td>I need some help to do it</td>
</tr>
<tr>
<td>19) Using the telephone</td>
<td>I can do this by myself</td>
<td>I need some help to do it</td>
</tr>
<tr>
<td>20) Housekeeping</td>
<td>I can do this by myself</td>
<td>I need some help to do it</td>
</tr>
<tr>
<td>21) Laundry</td>
<td>I can do this by myself</td>
<td>I need some help to do it</td>
</tr>
<tr>
<td>22) Driving or using transportation</td>
<td>I can do this by myself</td>
<td>I need some help to do it</td>
</tr>
<tr>
<td>23) Managing own finances</td>
<td>I can do this by myself</td>
<td>I need some help to do it</td>
</tr>
<tr>
<td>24) Taking your own medications</td>
<td>I can do this by myself</td>
<td>I need some help to do it</td>
</tr>
</tbody>
</table>

25) Do you use any devices? (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 ever leak urine or stool?
- Yes  
- No
SIGNS OF MEMORY ISSUES

Please check one response for each question:

29) Have you experienced any memory issues or problems with thinking?  □ Yes  □ No

30) Have any concerns about your memory been raised by family members, friends, caretakers, or others?  □ Yes  □ No

SCREENING AND PREVENTIVE SERVICES

31) Outside of UW Medicine, have you had any vaccinations or screening tests since your last wellness visit? (For example, cholesterol or diabetes screening blood tests, bone density tests, or cancer screening tests such as colonoscopy.) If so, please let us know which test(s) and where they were done:

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

ADVANCE CARE PLANNING

Please check one response for each question:

<table>
<thead>
<tr>
<th>Do you currently have any of these documents in place?</th>
</tr>
</thead>
<tbody>
<tr>
<td>32) POLST form (Physician orders for life-sustaining treatment)</td>
</tr>
<tr>
<td>33) Living will (documents that make your health care wishes known, also called Advance Directive)</td>
</tr>
<tr>
<td>34) Durable Power of Attorney for Medical Affairs (someone to make medical decisions for you in the event that you are unable to)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PROVIDER SIGNATURE</th>
<th>PRINT NAME</th>
<th>PAGER</th>
<th>NPI</th>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
</table>

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

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