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.):

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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:

2) Feeling stress over health, finances, relationships or work?	Not at all	Several days	More than half the days	Nearly every day
3) Body pain?	Not at all	Several days	More than half the days	Nearly every day
4) Feeling anger?	Not at all	Several days	More than half the days	Nearly every day

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?

13) Preparing food and eating	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
14) Bathing yourself	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me

15) Getting dressed	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
16) Using the toilet	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
17) Moving around from place to place	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
18) Shopping	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
19) Using the telephone	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
20) Housekeeping	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
21) Laundry	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
22) Driving or using transportation	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
23) Managing own finances	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me
24) Taking your own medications	☐ I can do this by myself	☐ I need some help to do it	☐ I cannot do this; another person needs to do it for me

25) Do you use any devices? (check all that apply):

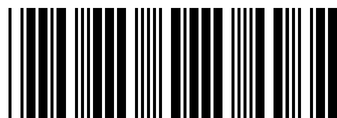
☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Special or built-up chair
☐ Built up or special utensils ☐ Devices used for dressing (button hook, zipper pull, etc.)
☐ None of the above

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

PLACE PATIENT LABEL HERE



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:

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ADVANCE CARE PLANNING

Please check one response for each question:

Do you currently have any of these documents in place?	
32) POLST form (Physician orders for life-sustaining treatment)	☐ Yes ☐ No ☐ Not sure
33) Living will (documents that make your health care wishes known, also called Advance Directive)	☐ Yes ☐ No ☐ Not sure
34) Durable Power of Attorney for Medical Affairs (someone to make medical decisions for you in the event that you are unable to)	☐ Yes ☐ No ☐ Not sure

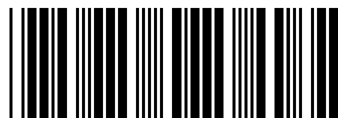
35) Do you want to discuss advance care planning at your wellness visit?
☐ Yes ☐ No ☐ Not sure

PROVIDER SIGNATURE	PRINT NAME	PAGER	NPI	DATE	TIME

PLACE PATIENT LABEL HERE

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

MEDICARE WELLNESS VISIT HEALTH RISK ASSESSMENT



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