MaineHealth

Medicare Annual Wellness Visit

Health Risk Assessment Questionnaire

Name: _____ Date of Birth: _____ Today's Date: _____

1. Have you had 2 or more falls in the last year? ___ Yes ___ No ___ Unknown
2. Have you had a fall with injury in the last year? ___ Yes ___ No ___ Unknown
3. Do you have difficulty with walking or balance? ___ Yes ___ No ___ Unknown
4. Are you deaf or do you have serious difficulty hearing? ___ No ___ Yes
5. Have you noticed any changes in your memory lately? ___ No ___ Yes
6. In the past 2 weeks, how often have you felt nervous, anxious, or on edge?
   ___ Almost never ___Some of the time ___ Most of the time ___ Almost all of the time
7. In the past 2 weeks, how often were you not able to stop worrying or control your worrying?
   ___ Almost never ___Some of the time ___ Most of the time ___ Almost all of the time
8. In general, would you say your health is? ___ Excellent ___ Good ___ Fair ___ Poor
9. How confident are you that you can manage most of your health problems?
   ___ Very confident ___Somewhat confident ___ Not very confident
   ___ I do not have any health problems
10. During the past 12 months, have you helped out a relative or friend with health and/or life tasks, even just a little bit? ___ No ___ Yes
11. Do you feel stressed by these caregiving/helping responsibilities? ___ No ___ Yes
12. In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking or using the toilet? ___ No ___ Yes
13. In the past 7 days, did you need help from others to take care of things such as laundry, housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your own medicine? ___ No ___ Yes
14. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
   ___Never ___Rarely ___Sometimes ___Often ___Always