MEDICARE AWV 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?	❑ Yes ❑ No
5. Have you noticed any changes in your memory lately?	❑ Yes ❑ No
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?	❑ Yes ❑ No
11. Do you feel stressed by these caregiving/helping responsibilities?	❑ Yes ❑ No
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?	❑ Yes ❑ No
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?	❑ Yes ❑ No
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