Health Risk Assessment: Medicare

Westfield Family Physicians P.C.

Name:_____ **Date:** _____

Date of birth: _____

1. During the past four weeks, how would you rate your health in general?
□ Excellent
□ Very good
□ Good
□ Fair
□ Poor

2. How have things been going for you over the past four weeks?
□ Very well, could hardly be better
□ Pretty well
□ Good and bad parts equal
□ Pretty bad
□ Very bad, could hardly be worse

3. Do you have any problems taking care of your health?
□ transportation
□ cost
□ Understanding
□ Family issues
□ No problems

4. 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

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 sick or lonely, needed help with chores or needed help caring for yourself)
□ Yes, as much as I wanted
□ Yes, quite a bit
□ Yes, a little
□ No, not at all

7. Can you get to places beyond walking distance without help? (can you travel alone or drive)
□ Yes □ No

8. Can you go shopping for groceries or clothes without help?
□ Yes □ No

9. Can you prepare your own meals?
□ Yes □ No

10. Can you do your housework without help?
□ Yes □ No

11. Do you need help of another person with your personal care such as eating, dressing or bathing?
□ Yes □ No

12. Can you handle your own money without help?
□ Yes □ No

13. During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad,downhearted or blue?
□ Not at all
□ Slightly
□ Quite a bit
□ Extremely

14. 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
□ Quite a bit
□ Extremely

15. Have you experienced a loss or significant event such a death, move, job loss,etc. in the past year?
□ No
□ 1 instance
□ 2 or more instances

16. Are you having difficulties driving your car?
□ Yes, often
□ Sometimes
□ No
□ Not applicable, I do not drive a car

17. Have you fallen two or more times in the past year?
□ Yes □ No

18. Are you afraid of falling?
□ Yes □ No

Name:_____ **Date:** _____

19. Do you have any of the following safety measures in place in your home? Mark yes or no.

	yes	no
Safety bars in the bathroom		
Smoke Detectors		
Carbon Monoxide detectors		
Automatic night lights		

20. Are you a smoker, or do you chew tobacco?
□ No
□ Yes, and I might quit
□ Yes, but I am not ready to quit

21. During the past four weeks, on average, 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

22. Do you exercise for at least 20 minutes 3 or more times per week?
□ Yes, most of the time
□ Yes, some of the time
□ No, I usually do not exercise this much

23. How often do you have trouble taking your 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

24. On average, how many times do you eat fast food, unhealthy snacks or pizza per week?
□ 0 □ 1 □ 2 □ 3 or more

25. On average, how many servings of fruit or vegetables did you eat each day?
□ 3 or more □ 2 □ 1 □ 0

26. On average, how many sodas and sugar sweetened drinks (1 cup servings) do you drink each day?
□ 0 □ 1 □ 2 □ 3 or more

27. How often do you choose whole grains instead of white? (for example: whole wheat bread or pasta)
□ most of the time □ sometimes □ never

28. Do you participate in activities such as:
□ Church □ volunteering □ clubs/civic org.
□ hobbies □ Senior groups or activities
□ none of the above

29. Do you have difficulty with your hearing?
□ Yes □ No

30. Do you have difficulty with your vision?
□ Yes □ No

31. When was your last dental visit? _____

32. When was your last eye exam? _____

33. Do you have a Health Care Proxy form filled out?
□ Yes (please bring a copy to the office)
□ No

34. Please list any specialists you see.

_____

_____

_____

35. What changes do you plan to make in the next six months to improve your health?
□ Quit smoking
□ Quit or cut down on alcohol
□ Increase exercise
□ Eat healthier
□ Reduce stress
□ Lose weight
□ None needed

Other concerns: _____

_____

Reviewed by: _____ Date: _____
(office use)