Today's Date: ___________________

Patient Name: ___________________

Annual Wellness Visit Health Risk Assessment

Personal Information

1. Preferred Pharmacy: ____
2. Preferred Lab: ____
3. Preferred imaging and x-ray facility: ____

Care Team

Specialty	Physician Name	Last Seen
Cardiology		
Dentist		
Dermatologist		
Ear, Nose & Throat (ENT)		
Endocrinologist		
Eye/Optometry/Ophthalmologist		
Gastroenterologist		
Gynecologist		
Hematologist/Oncologist		
Nephrologist		
Neurologist		
Orthopedist		
Podiatrist		
Pulmonologist		
Psychiatrist/Psychologist		
Rheumatologist		
Urologist		
Other:		

Have you seen a dentist within the last 6 months:	Yes	No

Pain Assessment

In the past 2 weeks, how often have you felt pain?

Never	Almost never	Sometimes	Most times	Almost all of the time

Where is the pain? ____

Rate your pain on the following scale:

1 🙂 | 2 😊 | 3 😐 | 4 🙁 | 5 😣 | 6 😖 | 7 😫 | 8 😩 | 9 😭 | 10 🤯

Allergies – Drugs, Food Environment

Medications – Prescriptions, Vitamins, Over-the-Counter

Name	Dose	Name	Dose

Self & Family History *(mark the columns that apply)*

	None	Self	Parent	Brother	Sister	Child
Congestive Heart Failure						
Diabetes						
COPD (Chronic Lung Disease) or Asthma						
Hypertension						
Stroke						
Kidney Disease						
Obesity						
Liver Disease						
Bipolar Disorder or Schizophrenia						
Dementia						
Cancer						
Depression						
Significant Surgeries:						

Functional Status Assessment

Are you able to care for yourself independently?	Yes	No	Note:
Are you blind or do you have difficulty seeing?	Yes	No	Note:
Are you use eyeglasses or contacts?	Yes	No	Note:
Are you deaf or have serious difficulty hearing?	Yes	No	Note:
Do you use hearing aids or other devices?	Yes	No	Note:
Do you have difficulty concentrating, remembering or making decisions?	Yes	No	Note:
Do you have difficulty walking or climbing stairs?	Yes	No	Note:
Do you have difficulty dressing, bathing, grooming or toileting?	Yes	No	Note:
Do you have difficulty doing errands alone?	Yes	No	Note:
Do you have transportation difficulties?	Yes	No	Note:

Physical Activity

How many days a week do you exercise?	0	1-2	3-4	5+	I don't know	
How intense is your exercise?	Light	Moderate	Heavy	Very Heavy	I don't know	I don't exercise

Tobacco, Alcohol and Drug Use

Do you use any tobacco products? (Cigarettes, chew, snuff, pipes, cigar)	Yes	No

If so, are you interested in quitting tobacco?	Yes	No	I don't use tobacco

How many times in the past year have you had 4 or more drinks in a day?	Never	Moderate	Heavy	Number of days:

Do you use any illegal drugs or take any prescription medications that have not been prescribed to you?	No	Yes (please describe):

Advance Directives

Does your family or friends know what you want in an emergency situation or if you could not speak for yourself:

No | Yes and I have completed (*mark all that apply):*

	A living will (Advance Directive)
	DNR
	Power of Attorney for Health Care
	POLST (in some states known as: POST, MOST, MOSLST, TPOPP)
	Five wishes

Would you like more information?

Yes	No	Unsure

Home/Safety

What is your housing situation like? (*mark all that apply):*

	Live with one or more children or dependent
	Live in an assisted living facility
	Live alone
	I have housing today, but I am worried about losing housing in the future
	I do not have housing (I am staying with others, on a beach, in a car, abandoned building, bus or train station or in a park

Social/Emotional Support

Which of the following applies to you? (*mark all that apply):*

	I have a supportive family
	I have supportive friends
	I participate in church, clubs, or other groups
	None

Would you like more information?

Yes	No	Unsure

Sleep

How many hours of sleep do you usually get?	0-3	4-6	7-10	I don't know
Do you snore, or has anyone told you that you snore?	Yes	No	I don't know	
In the past 7 days, how often have you felt sleepy during the day?	Often	Sometimes	Almost Never	Never
Have you ever been diagnosed with Sleep Apnea or other sleep disorders?	Yes	No	I don't know	
Are you currently using or have you used C-PAP/Bi-PAP?	Yes	No		

Depression Screening (PHQ-2)

In the past 2 weeks, how often have you been bothered by the following problems:	Not at all	Several Days:	More than half of those days:	Nearly every day:
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Total Score: _________

Steady Fall Risk (*mark all that apply):*

Yes	No	I have fallen in the past year
Yes	No	I use or have been advised to use a can or walker to get around safely
Yes	No	Sometimes I feel unsteady when I am walking
Yes	No	I steady myself by holding onto furniture when walking at home
Yes	No	I am worried about falling
Yes	No	I need to push with my hands to stand up from a chair
Yes	No	I have some trouble stepping up onto a curb
Yes	No	I often have to rush to the toilet
Yes	No	I have lost some feeling in my feet
Yes	No	I take medicine that sometimes makes me feel light-headed or more tired than usual
Yes	No	I take medicine to help me sleep or improve my mood
Yes	No	I often feel sad or depressed

Total Score: _________

Do you have a problem with the following at your home? (*mark all that apply):*

	Bug infestation
	Mold
	Lead pain or pipes
	Inadequate heat
	Oven or stove not working
	No or not working smoke detectors
	Water leaks
	None of the above

Do you feel safe in your home?	Yes	No	
Does your home have working smoke alarms?	Yes	No	I don't know
Do you have area rugs on your floor(s)?	Yes	No	
Do you have handrails in the bathroom?	Yes	No	
Do you have proper lighting in your home?	Yes	No	
Do you have handrails for the stairs?	Yes	No	I don't have stairs
Do you fasten your seatbelt in vehicles?	Yes	No	I don't ride in vehicles