ELLENBECKER PERSONALIZED MEDICINE

Modern Care, Intentional Focus

MEDICARE ANNUAL WELLNESS VISIT

Health Risk Assessment Questionnaire

Please complete this questionnaire prior to your Annual Wellness Visit. Your answers help us build and update your personalized prevention plan. There are no right or wrong answers — please answer as honestly as you can.

Full Name: _____ **Date of Birth:** _____

Today's Date: _____ **Visit Type:** _____

☐ First Annual Wellness Visit (Initial) ☐ Subsequent Annual Wellness Visit

DEMOGRAPHIC INFORMATION

Marital / Living Status:

☐ Married / Partnered ☐ Widowed ☐ Divorced / Separated ☐ Never Married

I currently live:

☐ Alone ☐ With spouse/partner ☐ With family ☐ In assisted living ☐ Other: _____

Highest Level of Education:

☐ Less than high school ☐ High school / GED ☐ Some college ☐ College degree or higher

SELF-REPORTED HEALTH STATUS

In general, how would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Compared to one year ago, how would you rate your health now?

☐ Much Better ☐ Somewhat Better ☐ About the Same ☐ Somewhat Worse ☐ Much Worse

CURRENT PROVIDERS & SUPPLIERS

Please list any other physicians, specialists, or medical equipment suppliers you currently see or use.

Provider / Supplier Name	Specialty / Type	Phone Number

FUNCTIONAL STATUS — ACTIVITIES OF DAILY LIVING

Please indicate your current level of ability for each activity.

	Independent	Need Some Help	Unable
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Toileting	☐	☐	☐
Transferring (bed/chair)	☐	☐	☐
Continence	☐	☐	☐
Feeding Yourself	☐	☐	☐

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INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Please indicate your current level of ability for each activity.

	Independent	Need Some Help	Unable
Using the Telephone	☐	☐	☐
Shopping	☐	☐	☐
Preparing Meals	☐	☐	☐
Housekeeping	☐	☐	☐
Laundry	☐	☐	☐
Transportation	☐	☐	☐
Managing Medications	☐	☐	☐
Managing Finances	☐	☐	☐

FALL RISK & MOBILITY

Have you fallen in the past 12 months?

☐ No ☐ Yes — number of falls: ___

Are you afraid of falling?

☐ No ☐ Yes

Do you use an assistive device?

☐ No ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

HEARING & VISION

Do you have difficulty hearing?

☐ No ☐ Yes — I use a hearing aid ☐ Yes — I do not use a hearing aid

Do you have difficulty seeing, even with glasses?

☐ No ☐ Yes

PAIN ASSESSMENT

Are you currently experiencing pain?

☐ No ☐ Yes

If yes, rate your pain today (0 = no pain, 10 = worst possible pain): _____

How does this pain affect your daily activities? _____

PSYCHOSOCIAL / EMOTIONAL HEALTH

Over the last 2 weeks, how often have you been bothered by the following?

	Not at all	Several days	More than half	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

Do you often feel lonely or isolated from others?

☐ No ☐ Yes

How satisfied are you with your life these days?

☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied

Do you often feel a lot of stress or anxiety?

☐ No ☐ Yes

BEHAVIORAL RISK FACTORS

Tobacco / Nicotine Use:

☐ Never ☐ Former ☐ Current

Alcohol Use — in a typical week:

Days per week you drink alcohol: _____

Typical number of drinks per day when you drink: _____

How often do you have 4+ (women) / 5+ (men) drinks on one occasion? _____

Physical Activity:

Days per week of moderate or vigorous exercise: _____

Typical minutes per session: _____

How would you describe your typical diet / nutrition? _____

Do you always wear a seatbelt when driving or riding in a car?

☐ Always ☐ Sometimes ☐ Never

Are firearms present in your home?

☐ No ☐ Yes — stored unloaded & locked ☐ Yes — other

Do you have working smoke detectors in your home?

☐ Yes ☐ No ☐ Unsure

COGNITIVE HEALTH

A brief cognitive assessment will also be completed with you during your visit.

Have you or your family noticed any changes in your memory or thinking?

☐ No ☐ Yes

If yes, please describe: _____

ADVANCE CARE PLANNING

Do you have an Advance Directive or Living Will?

☐ No ☐ Yes

Would you like information on completing an Advance Directive?

☐ No ☐ Yes

Who is your healthcare decision-maker if you are unable to make decisions? (Name & relationship):

_____

PREVENTIVE SCREENINGS — MOST RECENT DATE

Please list the approximate date you last received each of the following, if applicable.

Screening / Immunization	Date (or "N/A")

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Screening / Immunization	Date (or "N/A")

Colonoscopy · Mammogram · Bone Density (DEXA) · Flu Vaccine · Pneumonia Vaccine · Shingles Vaccine · Last Eye Exam · Last Dental Exam

Patient (or Guardian) Signature: _____ **Date:** _____

ANNUAL HEALTH HISTORY UPDATE

Please let us know about any changes since your last visit. If nothing has changed in a section, simply write "No Changes."

PATIENT INFORMATION

Full Name: _____ **Today's Date:** _____

NEW SURGERIES OR PROCEDURES SINCE LAST VISIT

List any surgeries, procedures, or hospitalizations since your last visit.

Procedure / Hospitalization	Date	Surgeon / Hospital (if known)

NEW MEDICAL HISTORY / DIAGNOSES SINCE LAST VISIT

List any new diagnoses, conditions, or significant health changes.

Condition / Change	Date Diagnosed	Notes

FAMILY HISTORY UPDATES

Note any new family health information since your last visit, with particular attention to cancer, diabetes, heart disease, and genetic conditions.

Relation	New Diagnosis / Change	Age at Diagnosis / Death

MEDICATION CHANGES SINCE LAST VISIT

Please list any medications started, stopped, or changed — including new supplements.

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Medication / Supplement	Started / Stopped / Changed	Dose & Frequency

NEW ALLERGIES SINCE LAST VISIT

Allergen	Reaction

SOCIAL HISTORY UPDATES

Please note any changes to tobacco, alcohol, or drug use.

Tobacco Use — any change? _____

Alcohol Use — any change? _____

Recreational / Other Drug Use — any change? _____

_____

ADDITIONAL INFORMATION

Is there anything else about your health you would like us to know before your visit?

_____

_____

Patient (or Guardian) Signature: _____ **Date:** _____