

Annual Wellness Visit

HEALTH RISK ASSESSMENT

Patient Name: _____ Date of Birth: _____

GENERAL HEALTH	
1. How is your overall health?	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> I don't know
2. How many different prescriptions are you taking?	<input type="checkbox"/> 0-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-10 <input type="checkbox"/> 10+ <input type="checkbox"/> I don't know
3. Do you take all of your medications as prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> Almost never <input type="checkbox"/> No <input type="checkbox"/> I don't take medication
4. How is the health of your mouth and teeth?	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> I don't know
5. Do you have a dentist that you visit regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
6. How many times in the last six months have you been to the emergency room?	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
7. How many times in the last six months were you admitted to the hospital?	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know

TOBACCO AND ALCOHOL USE, HCPCS CODES 99406, G0442	
8. Do you use any tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Are you interested in quitting tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't use tobacco
10. How many times in the past year have you had four or more alcoholic drinks in a day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+
11. Are you interested in receiving help for any other type of substance abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't use other substances

NUTRITION	
12. How many servings of fruits and vegetables do you usually eat each day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
13. How many servings of fiber or whole grain foods do you usually eat each day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
14. How many servings of meat, fish, or other protein do you usually eat each day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
15. How many servings of fried or high-fat foods do you usually eat each day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
16. How many servings of sugar-sweetened drinks do you usually have each day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know

PHYSICAL ACTIVITY	
17. How many days a week do you exercise?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
18. On the days that you exercised, how long did you exercise?	<input type="checkbox"/> 0-30 min. <input type="checkbox"/> 30 min. to 1 hour <input type="checkbox"/> More than 1 hour <input type="checkbox"/> I don't know <input type="checkbox"/> I don't exercise
19. How intense is your exercise?	<input type="checkbox"/> Light (stretching, slow walking) <input type="checkbox"/> Moderate (brisk walking) <input type="checkbox"/> Heavy (jogging, swimming) <input type="checkbox"/> Very heavy (running fast) <input type="checkbox"/> I don't know <input type="checkbox"/> I don't exercise

SLEEP	
20. How many hours of sleep do you usually get?	<input type="checkbox"/> 0-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-10 <input type="checkbox"/> 10+ <input type="checkbox"/> I don't know
21. Do you snore or has anyone told you that you snore?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
22. In the past seven days, how often have you felt sleepy during the daytime?	<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Almost never <input type="checkbox"/> Never <input type="checkbox"/> I don't know

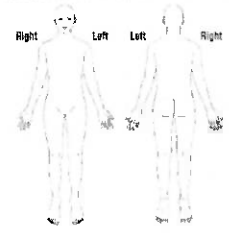
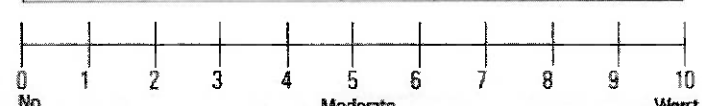
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HEALTH RISK ASSESSMENT

FUNCTIONAL STATUS ASSESSMENT, CPT II CODE 1170F

Instrumental activities of daily living		
23. Which of the following can you do on your own without help?	<input type="checkbox"/> Shop for groceries <input type="checkbox"/> Use the telephone <input type="checkbox"/> Housework <input type="checkbox"/> Handle finances	<input type="checkbox"/> Drive/use public transport <input type="checkbox"/> Make meals <input type="checkbox"/> Take medications <input type="checkbox"/> None
Activities of daily living		
24. Which of the following can you do on your own without help?	<input type="checkbox"/> Bath <input type="checkbox"/> Walk <input type="checkbox"/> Use the restroom	<input type="checkbox"/> Dress <input type="checkbox"/> Transfer (in/out of chairs, etc.) <input type="checkbox"/> None
25. Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know	
Ambulation status		
26. How long can you walk or move around?	<input type="checkbox"/> 0-5 min. <input type="checkbox"/> 5-15 min. <input type="checkbox"/> 15-30 min. <input type="checkbox"/> More than 1 hour <input type="checkbox"/> I don't know	
27. Which of these assistive devices do you use?	<input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Crutches <input type="checkbox"/> Other <input type="checkbox"/> None	
28. Do you have trouble with your balance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
29. Have you fallen in the last six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sensory ability		
30. Do you have problems with vision?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know	
31. Do you use eyeglasses or contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know	
32. Do you have problems with hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know	
33. Do you use hearing aids or other devices to help you hear?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know	

PAIN ASSESSMENT, CPT II CODES 1125F, 1126F

34. In the past two weeks, how often have you felt pain? <input type="checkbox"/> Almost all of the time <input type="checkbox"/> Most times <input type="checkbox"/> Sometimes <input type="checkbox"/> Almost never <input type="checkbox"/> No pain	35. Where is the pain? <input type="checkbox"/> No pain or Mark all areas indicated on the image <div style="text-align: center; margin-top: 10px;">  </div>	36. How do you treat the pain? <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Heat or cold <input type="checkbox"/> Therapy <input type="checkbox"/> Other <input type="checkbox"/> No treatment plan <input type="checkbox"/> No pain
37. Rate your pain on a scale of 0-10 with 0 being no pain and 10 being the worst pain: Circle the number on the scale		
<div style="background-color: #ccc; border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">0-10 Numeric pain intensity scale</div> 		

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HOME/SAFETY			
38. What is your living situation?	<input type="checkbox"/> Alone	<input type="checkbox"/> With my spouse or other family	
	<input type="checkbox"/> With a friend or roommate	<input type="checkbox"/> In a nursing home or assisted living facility/home	
	<input type="checkbox"/> I don't have a place to live	<input type="checkbox"/> Other	
39. Does your home have working smoke alarms?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> I don't know	<input type="checkbox"/> NA
40. Do you fasten your seatbelt in vehicles?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> I don't ride in vehicles	

DEPRESSION – (PHQ-9), HCPCS CODE G0444

In the last two weeks, how often have you been bothered by any of the following problems?			
41. Little interest or pleasure in doing things.	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> More than half the days
	<input type="checkbox"/> Nearly every day	<input type="checkbox"/> I don't know	
42. Feeling down, depressed, or hopeless.	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> More than half the days
	<input type="checkbox"/> Nearly every day	<input type="checkbox"/> I don't know	
43. Trouble falling or staying asleep or sleeping too much.	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> More than half the days
	<input type="checkbox"/> Nearly every day	<input type="checkbox"/> I don't know	
44. Feeling tired or having little energy.	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> More than half the days
	<input type="checkbox"/> Nearly every day	<input type="checkbox"/> I don't know	
45. Poor appetite or overeating.	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> More than half the days
	<input type="checkbox"/> Nearly every day	<input type="checkbox"/> I don't know	
46. Feeling bad about yourself or that you're a failure or have let yourself or your family down.	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> More than half the days
	<input type="checkbox"/> Nearly every day	<input type="checkbox"/> I don't know	
47. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> More than half the days
	<input type="checkbox"/> Nearly every day	<input type="checkbox"/> I don't know	
48. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you've been moving around a lot more than usual.	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> More than half the days
	<input type="checkbox"/> Nearly every day	<input type="checkbox"/> I don't know	
49. Thoughts that you would be better off dead or of hurting yourself.	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several days	<input type="checkbox"/> More than half the days
	<input type="checkbox"/> Nearly every day	<input type="checkbox"/> I don't know	
50. If you checked off any problems in this section, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	<input type="checkbox"/> Not at all	<input type="checkbox"/> Somewhat	<input type="checkbox"/> Very difficult
	<input type="checkbox"/> Extremely difficult		

SOCIAL/EMOTIONAL SUPPORT

51. Which of the following applies to you?	<input type="checkbox"/> I have a supportive family	<input type="checkbox"/> I have supportive friends	
	<input type="checkbox"/> I participate in church, clubs, or other group activities	<input type="checkbox"/> None	
52. How often do you get out and meet with family and friends?	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Almost never <input type="checkbox"/> None

ADVANCE DIRECTIVES, CPT II CODES 1157F, 1158F; HCPCS CODE S0257

53. Do you have a health care power of attorney or a living will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
54. Would you like more information?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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MEDICATIONS (PRESCRIPTIONS, VITAMINS, OVER THE COUNTER) CPT II CODE 1159F, 1160F			
Name	Dose	Date started	Condition treating

SELF AND 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					

OTHER PHYSICIANS OR HEALTH CARE PROVIDERS		
Specialty	Physician name	Date last seen
Cardiologist		
Pulmonologist		
Eye doctor		
Endocrinologist		
Physical therapist		
Gynecologist		
Dermatologist		
Ear, nose, and throat		

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ALLERGIES (DRUG, FOOD, ENVIRONMENT)	

OFFICIAL USE ONLY	
Reviewed by Clinician name:	
Clinician signature:	Date: