MEDICARE WELLNESS VISIT

Health Risk Assessment

Trinity Health
IHA Medical Group

Please complete the entire questionnaire completely so that your provider has complete and up to date information about you. Bring this with you to your appointment along with a list of your current medications*.

Medications - Please bring a list of ALL your medication to this visit including all vitamins, supplements or over-the-counter medications.

Name	Date of Birth	Today's Date

Medical History	Answer
Have there been any updates to your medical history in the past year?	☐ **Yes** ☐ **No** ☐ **Unsure**
If **yes**, what has changed?	
Have you seen any Medical Providers outside of the Trinity Health/IHA health system in the past year?	☐ **Yes** ☐ **No** ☐ **Unsure**
If **yes**, please provide Provider Name and Reason for visit	
Provider Name(s)	Reason
Provider Name(s)	Reason
Any Hospitalizations outside of Trinity Health in the past year?	☐ **Yes** ☐ **No** ☐ **Unsure**
Hospital Name(s)	Reason

General Health	Answer
How would you describe your typical physical function or exercise?	☐ Very heavy (such as fast running or stair climbing) ☐ Heavy (such as jogging or swimming) ☐ Moderate (such as brisk walking) ☐ Light (such as stretching or slow walking) ☐ I am not currently exercising.

In the last 7 days, did you have difficulty performing the following self-care activities?			
Eating	☐ **Yes** ☐ **No**	Getting dressed	☐ **Yes** ☐ **No**
Grooming	☐ **Yes** ☐ **No**	Bathing	☐ **Yes** ☐ **No**
Walking/Ambulating	☐ **Yes** ☐ **No**	Using the toilet	☐ **Yes** ☐ **No**
Shopping	☐ **Yes** ☐ **No**	Preparing food	☐ **Yes** ☐ **No**
Housekeeping	☐ **Yes** ☐ **No**	Doing laundry	☐ **Yes** ☐ **No**
Handling finances	☐ **Yes** ☐ **No**	Going places/Transportation	☐ **Yes** ☐ **No**
Using the telephone	☐ **Yes** ☐ **No**	Managing medications	☐ **Yes** ☐ **No**
Do you have any specific concerns performing any of these activities?	☐ **Yes** ☐ **No**		

Considering the last two weeks, how would you respond to the following questions?			
In general, how would you describe your health?			
☐ Excellent	☐ Very Good	☐ Fair	☐ Poor
How would you describe your overall life satisfaction?			
☐ Excellent	☐ Very Good	☐ Fair	☐ Poor
Have you had increased stress?			
☐ Nearly daily	☐ More than half the days	☐ A couple of days	☐ Not at all

Name	Date of Birth	Today's Date

Have you had increased anger?			
☐ Nearly daily	☐ More than half the days	☐ A couple of days	☐ Not at all
Have you felt social isolation or loneliness?			
☐ Nearly daily	☐ More than half the days	☐ A couple of days	☐ Not at all
Have you had more pain than usual?			
☐ Nearly daily	☐ More than half the days	☐ A couple of days	☐ Not at all
Have you experienced unusual fatigue?			
☐ Nearly every day	☐ More than half the days	☐ A couple of days	☐ Not at all
Have you felt down, depressed, or hopeless?			
☐ Nearly every day	☐ More than half the days	☐ Several days	☐ Not at all
Have little interest or pleasure in doing things?			
☐ Nearly every day	☐ More than half the days	☐ Several days	☐ Not at all

Generally, how would you describe your diet?			
☐ Healthy	☐ Standard	☐ Plant-based	☐ Poor
Special, please describe:			

Illegal or Recreational Drugs			
In the past year, how often have you used Illegal Drugs or Recreational Drugs?			
☐ Nearly every day	☐ More than half the days	☐ A couple of days	☐ Not at all
If yes, are you interested in interventional resources?	☐ **Yes** ☐ **No** ☐ **Unsure**		

Additional Questions:		
Do you have any teeth issues or dental problems?	☐ Yes ☐ No	
Do you have any concerns about sexual activity?	☐ Yes ☐ No	
Do you drink alcohol?	☐ Yes ☐ No	
Do you use tobacco?	☐ Yes ☐ No	
Do you use your seatbelt in a vehicle?	☐ Yes ☐ No	
Do you feel unsteady when standing or walking?	☐ Yes ☐ No	
Have you experienced a fall in the last year?	☐ Yes ☐ No	
Do you feel safe within your home?	☐ Yes ☐ No	
Do you have the following home Safety Detectors:	**Smoke:**	☐ Yes ☐ No
	Carbon Monoxide:	☐ Yes ☐ No
Has a first-degree relative been diagnosed with any of the following? **(mother, father, siblings, children)**	**Cancer**:	☐ Yes ☐ No
	Heart Attack	☐ Yes ☐ No
	Mental Illness	☐ Yes ☐ No
	Stroke	☐ Yes ☐ No
	Unknown	☐ Yes ☐ No
	If unknown, why?	
Do you have an Advanced Directive in place? Advanced Directives (Durable Power of Attorney for Healthcare) are documents that can help ensure your wishes are followed in the instance you cannot make your own medical decisions. If yes, please bring a copy with you so that we can add it to your record.	☐ **Yes** ☐ **No** ☐ **Unsure**	
If no, would you like some information?	☐ **Yes** ☐ **No**	

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PROVIDER SIGNATURE DATE