Gagneja Health
Priti Gagneja, MD FACP

Patient Name:_____

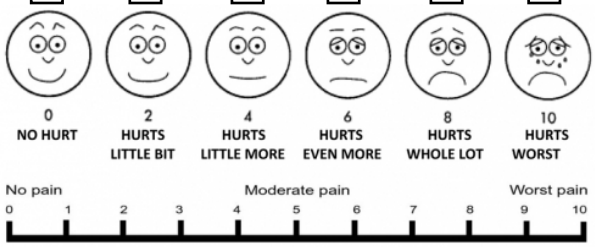
MRN: _____

MEDICARE ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT

Today's Date: _____

Patient Name: _____ Date of Birth: _____

What is your primary language spoken at home?	☐ English ☐ Spanish Other:	
How is your overall health?	☐ Excellent ☐ Good ☐ Fair ☐ Poor	
What are your biggest concerns about managing your health? ***Check all that apply***	☐ None – I have no concerns ☐ I live in an unsafe environment ☐ Transportation to appointments ☐ Financial difficulty in paying for services/medicines ☐ Difficulty taking or remembering my medicines ☐ Difficulty reading or understanding instructions ☐ I am lonely or don't have a lot of support at home ☐ I am often very tired ☐ I experience a lot of stress or anger	
What is your housing situation like? ***Check all that apply***	☐ Live with one or more children or dependent ☐ Live with Spouse or Partner ☐ Live in an assisted living facility ☐ Live in a nursing 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, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) ☐ Lead paint or pipes ☐ Inadequate heat ☐ Oven or stove not working ☐ No (or not working) smoke detectors ☐ Water leaks	
Do you feel safe in your home?	☐ Yes ☐ No	
Which of the following are in your home?	☐ Throw rugs ☐ Handrails in the bathroom	☐ Proper lighting ☐ Handrails for stairs ☐ No stairs in home

Which of the following do you need help with?	☐ Bathing ☐ Getting dressed ☐ Eating ☐ Walking ☐ Using the restroom ☐ Using the telephone ☐ Housework ☐ Laundry	☐ Handling finances ☐ Driving/Using public transportation ☐ Taking medication ☐ Making meals ☐ Transferring in/out of chairs, etc. ☐ Shopping for groceries ☐ None - I can do all of these without help.
Which of the following applies to you? ***Please check all that apply***	☐ I have a supportive family ☐ I have supportive friends	☐ I participate in church, clubs, or other groups ☐ None
How often do you get the social and emotional support you need?	☐ Always ☐ Usually ☐ Sometimes	☐ Rarely ☐ Never
Do you use any sensory devices?	☐ Contact Lenses ☐ Glasses ☐ Hearing Aid ☐ I have no devices but concerns about: ☐ Hearing ☐ Vision	
Do you or your family members have any concerns about your memory?	☐ Yes ☐ No	
Many people experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experienced leaking of urine?	☐ Yes ☐ When cough/sneeze	☐ No ☐ I don't know
In the past 2 weeks, how often have you felt pain?	☐ Almost all the time ☐ Most times ☐ Sometimes	☐ Almost never ☐ Never
Rate your pain on the following scale: ☐ ☐ ☐ ☐ ☐ ☐  	Describe where on your body you experience pain and how do you treat the pain:	

Which of these assistive devices do you use? ***Please check all that apply***	☐ Cane ☐ Walker ☐ Wheelchair	☐ Crutches ☐ Other ☐ None
Have you fallen in the past year?	☐ Yes – 1 time ☐ Yes- 2 or more times ☐ No- I have not fallen in the past year	
Are you afraid of falling?	☐ Yes	☐ No
If you use any tobacco products, are you interested in quitting?	☐Yes ☐No ☐NA-I don't use tobacco products.	
How many days in a week do you drink alcohol?	☐0 ☐1-2 ☐3-4 ☐5-6 ☐7	
How many alcoholic drinks to you have in a typical week?	☐0 ☐1-2 ☐3-6 ☐7-10 ☐10 or more	
Do you use any illegal drugs?	☐ Yes (please describe): ☐ No	
Do you take any prescription medications that have not been prescribed to you?	☐ Yes (please describe): ☐ No	
Do you fasten your seatbelt in vehicles?	☐Yes ☐No ☐I don't ride in vehicles	
Do you have questions or concerns about your dietary needs or nutrition?	☐Yes ☐No	
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
How many hours of sleep do you usually get?	☐0-3 ☐4-7 ☐8-10 ☐10+ ☐I don't know	
Do you snore, has anyone told you that you snore, or do you currently use a sleep device?	☐Yes ☐No ☐I don't know	
Have you had any problems with your teeth or dentures?	☐Yes ☐No	
Are you having any sexual problems you would like to discuss?	☐Yes ☐No	

DEPRESSION SCREENING (PHQ-2)				
In the past 14 days, how often have you been bothered by the following problems:	**Not at all:**	**2-6 Days:**	**7-12 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: ☐

ADVANCE DIRECTIVES	
Does your family or friends know what you want in an emergency situation or if you could not speak for yourself? ***Check all that apply*** *If you have any of the following, it would be helpful to have a copy provided to us for your medical record.*	☐ No Yes, and I have completed: ☐ A living will ☐ Advance Directive ☐ Power of Attorney for Health Care ☐ POLST (in some states known as: POST, MOST, MOLST, TPOPP) ☐ Five Wishes document

	Relationship to Patient:
Signature:	**Date:**

Gagneja Health does not and shall not discriminate on the basis of race, color, national origin, ancestry, age, sex, sexual orientation, marital status, religion, disability or any other characteristic protected by law.