



497 W Lott Buffalo, WY 82834

FAMILY MEDICAL CENTER
Medicare Wellness Visit Health Risk Assessment Form
Welcome to Medicare, First, Subsequent Visits

PATIENT: _____ DATE OF BIRTH: _____

DATE OF SERVICE: _____

This questionnaire is used for all Welcome to Medicare Visits, First and Subsequent Annual Wellness Visits (AWV).

Please take the time to fill out this questionnaire prior to your appointment. Your answers to all the following questions will help the provider identify your preventive care needs and possible health risks, and allow more time for discussion during the visit.

Please list your past medical history (surgeries, injuries and major illness).

PAST PERSONAL INJURY OR ILLNESS/SURGERY	DATE	HOSPITALIZED?

Do you have any food, environmental, or drug allergies? NO YES (Please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? NO and never have YES (Please explain below)

TYPE OF TOBACCO cigarette, chew, etc.	HOW MUCH	HOW OFTEN

Do you drink alcohol? NO and never have YES (Please explain below)

TYPE OF ALCOHOL	HOW MUCH	HOW OFTEN

Any recreational drug uses? NO and never have YES (Please explain below)

TYPE OF DRUGS	HOW MUCH	HOW OFTEN

Describe your diet:

Do you exercise? NO YES

How often? _____



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Please list all medications (prescription and non-prescriptions) that you take. Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions, etc. If you need more space, please attach list.

MEDICATIONS	DOSAGE	MEDICATION	DOSAGE

Are you currently treated with pain medication? Yes No

Family Medical History:

FAMILY MEMBER	MEDICAL CONDITIONS
Mother	
Father	
Sibling(s)	
Other:	

Vaccines and Immunizations:

VACCINATION / IMMUNIZATIONS	YEAR(S)
Hepatitis B?	
Pneumonia?	
COVID-19?	
Zoster, Shingrix (shingles)?	
Respiratory Syncytial Virus (RSV)?	
Influenza yearly? <input type="checkbox"/> Yes <input type="checkbox"/> Some years <input type="checkbox"/> No	
If some years or no, reason:	

Procedure History:

TEST / PROCEDURE	DATE (if unsure, estimate year)	RESULT – Abnormal?
Mammogram		
Colonoscopy		
Bone Density Scan (DEXA)		
Pap Smear		
Hep C Screening		
HIV Screening		
Prostate-Specific Antigen (PSA)		

Please list care providers who are outside JCHC (including specialists, eye doctor etc.).

CARE PROVIDERS	SPECIALIST	FACILITY

Please list any durable medical equipment providers (ex. Oxygen or CPAP companies).

NAME OF COMPANY	TYPE OF DME



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Please select one response for each question:

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things:

- 0 = Not at all 1 = Several days 2 = More than half the day 3 = Nearly every day

Feeling down, depressed, or hopeless:

- 0 = Not at all 1 = Several days 2 = More than half the day 3 = Nearly every day

Total patient score: _____

Have you had any recent falls? Yes No

Do you feel safe at home? Yes No

Do you find yourself having trouble hearing people speak? Yes No

Do you have concerns or trouble with your memory? For example, do you get lost in familiar places, forgetfulness?

- Frequently Sometimes Rarely Never

How much difficulty do you have with the following activities?

Preparing food and eating	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
Bathing Yourself	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
Getting dressed	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
Using the restroom	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
Moving around from place to place	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
Shopping	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
Using telephone	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
Housekeeping	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
Laundry	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
Driving	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
Managing own finances	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me
Taking your own medications	<input type="checkbox"/> I can do this by myself	<input type="checkbox"/> I need some help to do it	<input type="checkbox"/> I cannot do this; another person needs to do it for me



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Advance Care Planning:

Do you currently have any of these documents in place?

POLST form - Physician orders for life-sustaining treatment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Sure
Living Will / Advance Directive – Document that makes your health care wishes known	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Sure
Durable Power of Attorney for Medical Affairs – someone to make medical decisions for you in the event that you are unable to	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Sure

Do you want to discuss advance care planning at your wellness visit? No Yes Not Sure

STAFF WILL FILL OUT BELOW THIS LINE

Height: _____ Weight: _____ BMI: _____

Vision: Bilateral 20/____ Right 20/____ Left 20/____