Medicare Health Risk Assessment

Please complete this checklist before seeing your provider. Your responses will help us optimize your care.

Today's Date: ____________ Patient Name: ____________ DOB: ____________

Overall Health Status

1. In general, would you say your health is:
   - ❑ Excellent
   - ❑ Very good
   - ❑ Good
   - ❑ Fair
   - ❑ Poor

2. During the past four weeks, has your physical health limited your social activities with family, friends, neighbors, or groups?
   - ❑ Not at All
   - ❑ Some of the Time
   - ❑ Quite a bit
   - ❑ Almost all of the Time

3. On average, how many days per week do you engage in moderate to strenuous exercise or movement (like a brisk walk)?

❑ 0 days per week	❑ 1 day per week	❑ 2 days per week
❑ 3 days per week	❑ 4 days per week	❑ 5 days per week
❑ 6 days per week	❑ 7 days per week	

4. On average, how many minutes per day do you engage in this type of exercise?

❑ 0 min	❑ 10 min	❑ 20 min	❑ 30 min
❑ 40 min	❑ 50 min	❑ 60 min	❑ 70 min
❑ 80 min	❑ 90 min	❑ 100 min	❑ 110 min
❑ 120 min	❑ 130 min	❑ 140 min	❑ 150+ min

ADDITIONAL FORMS MAY BE OBTAINED FROM [illegible] PRINTING SERVICES BY CALLING [illegible]

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND MRN IN SPACE BELOW

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Mental Health and Pain/Fatigue

5. In the **past 2 weeks,** how often have you experienced the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Feeling little interest or pleasure in doing things.	❑	❑	❑	❑
Feeling down, depressed, or hopeless.	❑	❑	❑	❑
Feeling nervous, anxious, or on edge.	❑	❑	❑	❑
Not being able to stop worrying or control worrying.	❑	❑	❑	❑

6. How hard is it for you to pay for the very basics like food, housing, medical care, and utilities?
   ❑ Very hard ❑ Hard ❑ Somewhat hard ❑ Not very hard ❑ Not hard at all

7. During the **past four weeks,** how much bodily pain have you felt?
   ❑ None ❑ Some ❑ A moderate amount ❑ A lot

8. During the **past four weeks,** how often would someone have been available to help you if you had needed and wanted help? (For example, if you were injured, sick, or needed help with daily chores or taking care of yourself)
   ❑ Never ❑ Rarely ❑ Some of the time ❑ Usually ❑ Always

9. Do you often feel that you lack companionship?
   ❑ Yes ❑ No

10. What is your marital status?
   ❑ Married ❑ Widowed ❑ Divorced
   ❑ Separated ❑ Never married ❑ Living with a partner
   ❑ Other:______________________________

Behavioral Risks

11. Do you fasten your seat belt when you are in the car?
   ❑ Yes ❑ Sometimes ❑ No

12. How many hours of sleep do you usually get at night?
   ❑ Less than 5 hours
   ❑ Between 5 and 7 hours
   ❑ Between 7 and 9 hours
   ❑ More than 9 hours

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Behavioral Risks

13. Have you fallen 2 or more times in the **past year**?
❑ Yes ❑ No

14. Have you fallen and hurt yourself in the **past year**?
❑ Yes ❑ No

15. Are you afraid that you might fall because of balance of walking problems?
❑ Yes ❑ No

16. How do you move from one place to another?
❑ Walk without aid ❑ Walker ❑ Furniture/fixture/hand-hold ❑ Cane ❑ Crutches
❑ Wheelchair/independently ❑ Wheelchair bound, dependent on other ❑ Bedbound
❑ Other:______________________________

17. How often during the **past four weeks** have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Trouble eating nutritious food	❑	❑	❑	❑	❑
Teeth or denture problems	❑	❑	❑	❑	❑
Sexual problems	❑	❑	❑	❑	❑
Urinary incontinence	❑	❑	❑	❑	❑
Constipation	❑	❑	❑	❑	❑
Hearing problems	❑	❑	❑	❑	❑
Visual problems	❑	❑	❑	❑	❑
Feeling tired during the daytime	❑	❑	❑	❑	❑
Feeling unsafe at home	❑	❑	❑	❑	❑

18. In the last year, how many places have you lived?
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 or more

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19. Safety Assessment:

	Yes	No	N/A
Are firearms stored unloaded and securely locked?	❑	❑	❑
Do you have working smoke alarms in your home?	❑	❑	❑
Have throw rugs been removed or fastened down?	❑	❑	❑
Are electrical cords in working order, easily seen, and out of the walking path?	❑	❑	❑
Are non-slip mats in all bathtubs and showers?	❑	❑	❑
Do all stairways have a working rail or banister?	❑	❑	❑
Are doorways, walkways, and stairs free of clutter?	❑	❑	❑
In the places you walk outside, are there uneven surfaces, cracked sidewalks, slippery steps, or other problems that may make you stumble?	❑	❑	❑
Do you have good lighting when you walk into your house?	❑	❑	❑
If you were to fall and were unable to get up, would you be able to get help quickly?	❑	❑	❑
Do you slip or have difficulty getting on and off the toilet or in and out of the bath or shower?	❑	❑	❑
Have you been known to leave the stove on or water running?	❑	❑	❑
In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?	❑	❑	❑
In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?	❑	❑	❑
In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?	❑	❑	❑
In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?	❑	❑	❑

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Activities of Daily Living

20. For each of the following, please check how you are able to perform:

	Independent	With assistance	Dependent
Bathing	❑	❑	❑
Dressing	❑	❑	❑
Feeding	❑	❑	❑
Using the toilet	❑	❑	❑
Grooming (brushing teeth or hair)	❑	❑	❑
Getting around the house	❑	❑	❑

Additional Activities

21. Do you get to places beyond walking distance without help?
(For example, can you travel alone on buses or taxis, or drive your own car?)
❑ Yes ❑ No

22. If you drive, are you having difficulties driving your car?
❑ Yes, often ❑ Sometimes ❑ No problems ❑ I do not drive a car

23. Please indicate whether you are able to do each of the following the activities without help:

	Yes	No
Shopping for groceries or clothes without help	❑	❑
Prepare your own meals	❑	❑
Do housework without help (for example, laundry)	❑	❑
Use a telephone without help	❑	❑
Handle your own money and bills	❑	❑

24. Do you handle your own medications without help?
❑ Yes
❑ No, someone sets up a pillbox for me
❑ No, someone administers my medications to me
❑ I do not take medication

25. Within the past 12 months, have you worried that your food would run out before you got money to buy more?
❑ Never true ❑ Sometimes true ❑ Often true

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Additional Activities

26. Within the past 12 months, how often did the food you bought not last, and you didn't have the money to get more?
    - ❑ Never true
    - ❑ Sometimes true
    - ❑ Often true

Drug, Tobacco and Alcohol Use

27. How many times in the past year have you used an illegal drug or a prescription medication for nonmedical reasons?
    - ❑ Never
    - ❑ Sometimes
    - ❑ Often

28. Are you a smoker or other tobacco user?
    - ❑ No
    - ❑ Yes, and I might quit soon
    - ❑ Yes, but I'm not ready to quit

29. How often do you have a drink containing alcohol?
    - ❑ Never
    - ❑ Monthly or less
    - ❑ 2-4 times/month
    - ❑ 2-3 times/week
    - ❑ At least 4 times/week

30. How many drinks containing alcohol do you have on a typical day when you are drinking?
    - ❑ none
    - ❑ 1 or 2 drinks
    - ❑ 3 or 4 drinks
    - ❑ 5 or 6 drinks
    - ❑ 7 to 10 drinks
    - ❑ More than 10 drinks

31. How often do you have six or more drinks on one occasion?
    - ❑ Never
    - ❑ Monthly
    - ❑ Weekly
    - ❑ Daily/Almost daily

Thank you very much for completing your Medicare Health Risk Assessment checklist.
Please give the completed checklist to your doctor or nurse.