



# University Physicians

University of Missouri Health Care

## Fairview General Internal Medicine

### Medicare Wellness Visit: Health Risk Assessment

#### Current List of Medical Providers, Suppliers:

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Medical Equipment: \_\_\_\_\_

Home Health: \_\_\_\_\_

Physical Therapy: \_\_\_\_\_

#### Please describe the following regarding your health:

##### In general, would you say your health is

Excellent

Very good

Good

Fair

Poor

Comment: \_\_\_\_\_

##### How would you describe the condition of your mouth and teeth—including false teeth or dentures?

Excellent

Very good

Good

Fair

Poor

Comment: \_\_\_\_\_

##### How would you describe your hearing?

Excellent

Very good

Good

Fair

Poor

Comment: \_\_\_\_\_

### Activities of Daily Living (ADLs)

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

- Yes Comment: \_\_\_\_\_
- No

### Instrumental Activities of Daily Living (IADLs)

In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

- Yes Comment: \_\_\_\_\_
- No

### Physical Activity

In the past 7 days, how many days did you exercise? \_\_\_\_\_ days

On days when you exercised, for how long did you exercise (in minutes)? \_\_\_\_\_ minutes/day  Does not apply

How intense was your typical exercise?

- Light (like stretching or slow walking)
- Moderate (like brisk walking)
- Heavy (like jogging or swimming)
- Very heavy (like fast running or stair climbing)
- I am currently not exercising

### Sleep

Each night, how many hours of sleep do you usually get? \_\_\_\_\_ hours

Do you snore or has anyone told you that you snore?

- Yes
- No

In the past 7 days, how often have you felt sleepy during the daytime?

- Always
- Usually
- Sometimes
- Rarely
- Never

### Alcohol Use

In the past 7 days, on how many days did you drink alcohol? \_\_\_\_\_ days

On days when you drank alcohol, how often did you have 4 or more alcoholic drinks on one occasion?

- Never
- Once during the week
- 2–3 times during the week
- More than 3 times during the week

Do you ever drive after drinking, or ride with a driver who has been drinking?

- Yes
- No

**Seat Belt Use**

Do you always fasten your seat belt when you are in a car?

- Yes
- No

**Nutrition**

In the past 7 days, how many servings of fruits and vegetables did you typically eat each day?

(1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.)

\_\_\_\_\_ servings per day

In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day?

(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)

\_\_\_\_\_ servings per day

In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day?

(Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)

\_\_\_\_\_ servings per day

In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?

\_\_\_\_\_ sugar sweetened beverages consumed per day

**Home Safety**

In the past 6 months, have you fallen in your home and/or sustained an injury related to a fall in your home?

- Yes Comment: \_\_\_\_\_
- No

Do you think that your home would be made safer by any of the following measures?

(Removing tripping hazards in walkways, using non-slip mats in bathtubs and showers, placing grab bars next to the toilet and shower, placing handrails on both sides of a stairway, improving home lighting)

- Yes Comment: \_\_\_\_\_
- No

**End-Of-Life Planning**

Do you currently have an advanced directive for health care?

(Example: Durable Power of Attorney for Health Care, Living Will, DNAR Order)

- Yes
- No
- I do not wish to discuss end-of-life planning with my provider at this time