Medicare Health Risk Assessment

Name___________________________________

DOB__________________________

Today's Date_____________________

1. What is your gender?

☐ Male ☐ Female

2. What is your race? (check all that apply)

☐ White
☐ Black/African American
☐ Asian or Pacific Islander
☐ American Indian
☐ Hispanic or Latino
☐ Other ____________________________

3. During the past two weeks, have you felt down, depressed, anxious, irritable or hopeless?

☐ Yes ☐ No

4. During the past two weeks, have you felt little interest or pleasure in doing things?

☐ Yes ☐ No

5. During the past four weeks, has your physical or emotional health limited your social activities with family or friends?

☐ Yes ☐ No

6. During the past four weeks, how much bodily pain have you had?

☐ None ☐ Moderate
☐ Mild ☐ Severe

7. During the past four weeks, how often have you been bothered by fatigue?

☐ Not at all

☐ Sometimes

☐ Frequently

☐ Always

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)

☐ Yes ☐ No

9. Can you go shopping for groceries or clothes without someone's help?

☐ Yes ☐ No

10. Can you do your housework without help?

☐ Yes ☐ No

11. Can you handle your own money without help?

☐ Yes ☐ No

12. Can you prepare your own meals?

☐ Yes ☐ No

13. Can you manage your medications without help?

☐ Yes ☐ No

14. Do you exercise for at least 20 minutes three or more days per week?

☐ Yes ☐ No
☐ Some of the time

15. Do you always fasten your seatbelt when you are in a car?

☐ Yes ☐ No

16. During the past four weeks, was someone available to help you if you needed and wanted help? (For example, if you felt nervous or sad, got sick, needed someone to talk to, or needed help taking care of yourself)

☐ Yes, as much as I wanted
☐ Yes, somewhat
☐ No, not at all

TURN OVER →

17. Because of any health problems, do you need the help of another person with your personal care needs, such as eating, bathing, dressing or getting around the house?

☐ Yes ☐ No

18. Have you fallen two or more times in the past year?

☐ Yes ☐ No

19. Are you afraid of falling?

☐ Yes ☐ No

20. Are you a smoker?

☐ Yes ☐ No

21. During the past four weeks, how many alcoholic beverages did you consume?

☐ None
☐ 1-5 drinks per week
☐ 6-9 drinks per week
☐ 10 or more drinks per week

22. Are you having difficulties driving your car?

☐ Yes ☐ No
☐ I do not drive

23. Do you have any difficulties with your hearing?

☐ Yes ☐ No

24. Are you having problems using the telephone?

☐ Yes ☐ No

25. Do you have any concerns about your sexual health?

☐ Yes ☐ No

26. Are you having trouble eating well?

☐ Yes ☐ No

27. Do you have any dental or denture problems?

☐ Yes ☐ No

28. Are there any hazards in your home that may hurt you? (For example, rugs in the hallway, lack of handrails on the stairs, poor lighting, electrical cords in walking areas)

☐ Yes ☐ No
☐ Not sure

29. How confident are you that you can control and manage your health?

☐ Very confident
☐ Somewhat confident
☐ Not very confident

30. How would you rate your overall health?

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor