

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Date of visit: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

**MEDICARE HRA**

**Current Living Arrangement**

- Alone
- Spouse/Significant Other
- Family Member
- Assisted Living facility
- Retirement community
- Other

**During the past 4 weeks, how much pain in your body have you had on a scale of -10?**

- No pain (0)
- Very mild pain (1-2)
- Mild pain (3-4)
- Moderate pain (5-6)
- Moderately severe pain (7-8)
- Severe pain (9-10)

**During the past 4 weeks, was someone available to help you if you needed and wanted help?**

- No assistance needed
- Yes, as much as I wanted
- Yes, quite a bit
- Yes, some
- Yes, a little
- No, not at all

**During the past 4 weeks, what was the hardest level of physical activity you could do for at least 2 minutes?**

- Very heavy
- Heavy
- Moderate
- Light
- Very light

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

# of hours: \_\_\_\_\_

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

- No
- Yes

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

- Yes
- No



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(or use patient label)

Name / MR # / Label

**Do you drive after drinking alcohol or ride with a driver who has been drinking?**

- No
- Yes

**How often during the past 4 weeks have you been bothered by falling or dizziness when standing up?**

- Never
- Seldom
- Sometimes
- Often
- Always

**How often during the past 4 weeks have you been bothered by sexual problems?**

- Never
- Seldom
- Sometimes
- Often
- Always

**Do any of the following describe you? Multiple sexual partners and/or intercourse with partner of the same sex**

- No
- Yes

**How often during the past four weeks have you been bothered by teeth or denture problems?**

- Never
- Seldom
- Sometimes
- Often
- Always

**How often during the past four weeks have you been bothered by tiredness or fatigue?**

- Never
- Seldom
- Sometimes
- Often
- Always

**During the past four weeks, how would you rate your health in general?**

- Excellent
- Very good
- Good
- Fair
- Poor



**NHMG Annual Wellness Visit Patient Questionnaire**

806370 R 01/05/2021

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Name / MR # / Label

**What is your race?** (Check all that apply)

- American Indian or Alaskan Native
- Asian
- Black or African-American
- Hispanic or Latino origin
- White
- Other

**FUNCTIONAL AND COGNITIVE ASSESSMENT**

**Is this person deaf or does he/she have serious difficulty hearing?**

- No
- Yes

**Is this person blind or does he/she have serious difficulty seeing even when wearing glasses?**

- No
- Yes

**Do you/patient have serious difficulty concentrating, remembering, or making decisions?**

- No
- Yes

**Have you had any concerns about changes in your memory or concentration?**

- No
- Yes

**ADL ASSESSMENT**

**Please select any of the following that you have serious difficulty managing on your own:**

- None apply
- Walking
- Climbing stairs
- Dressing
- Bathing
- Going to the toilet
- Feeding yourself
- Eating

**Please select any of the following that you have serious difficulty managing on your own:**

- None apply
- Interacting with others
- Driving
- Shopping
- Managing your money
- Preparing meals
- Managing medication
- Using the telephone
- Doing housework



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806370 R 01/05/2021

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**PHYSICAL ACTIVITY**

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

- 0 days
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days
- Patient refused

**On average, how many minutes do you engage in exercise at this level?**

- 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
- Patient refused

**FINANCIAL RESOURCE STRAIN**

**How hard is it for you to pay for the very basics like food, housing, medical care, and heating?**

- Very hard
- Hard
- Somewhat hard
- Not very hard
- Not hard at all
- Patient refused

**HOUSING SCREENER**

**In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?**

- Yes
- No
- Patient refused



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806370 R 01/05/2021

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In the last 12 months, how many places have you lived? Enter number here: \_\_\_\_\_

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)?

- Yes
- No
- Patient refused

**TRANSPORTATION NEEDS**

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

- Yes
- No
- Patient refused

In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?

- Yes
- No
- Patient refused

**FOOD INSECURITY**

Within the last 12 months, you worried that your food would run out before you got the money to buy more.

- Never true
- Sometime true
- Often true
- Patient refused

Within the last 12 months, the food you bought just didn't last and you didn't have money to get more.

- Never true
- Sometime true
- Often true
- Patient refused

**STRESS**

Do you feel stress – tense, restless, nervous, anxious, or unable to sleep at night because your mind is troubled all the time – these days?

- Not at all
- Only a little
- To some extent
- Rather much
- Very much
- Patient refused



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**SOCIAL CONNECTIONS**

**In a typical week, how many times do you talk on the phone with family, friends, or neighbors?**

- Never
- Once a week
- Twice a week
- Three times a week
- More than three times a week
- Patient refused

**How often do you get together with friends or relatives?**

- Never
- Once a week
- Twice a week
- Three times a week
- More than three times a week
- Patient refused

**How often do you attend church or religious service?**

- Never
- 1 to 4 times per year
- More than 4 times per year
- Patient refused

**Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?**

- Yes
- No
- Patient refused

**How often do you attend meetings of the clubs or organizations you belong to?**

- Never
- 1 to 4 times per year
- More than 4 times per year
- Patient refused

**Are you married, widowed, divorced, separated, never married, or living with a partner?**

- Married
- Widowed
- Divorced
- Separated
- Never married
- Living with a partner
- Patient refused



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**ALCOHOL USE**

**How often do you have a drink containing alcohol?**

- Never
- Monthly or less
- 2-4 times a month
- 2-3 times a week
- 4 or more times a week
- Patient refused

**How many drinks containing alcohol do you have on a typical day when you are drinking?**

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more
- Patient refused

**How often do you have six or more drinks on one occasion?**

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily
- Patient refused

**PERSONAL DATA SHEET**

**Do you depend on people living with you for personal care?**

- No
- Yes

**Are there any cultural or religious beliefs that your healthcare provider should be aware of that would be helpful in your health care?**

- Yes
- No

**If you answered yes above, please list those here:**

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**ADVANCE CARE DIRECTIVES**

**Do you have a living will?**

- No
- Yes

**Do you have a Healthcare Power of Attorney?**

- No
- Yes

**If you answered yes above, who is your Healthcare Power of Attorney?**

Write name here: \_\_\_\_\_

**FALL RISK SCREENING**

**Are you able to walk?**

- Yes
- No

*If you answered **No**, then you **may skip** the remainder of the questions below.*

In the last year, have you had 2 or more falls, trips or stumbles where you landed on the ground?

- No
- Yes

In the last year, have you had 1 or more falls, trips or stumbles where you hurt yourself?

- No
- Yes

*If you answered **No**, then you **may skip** the remainder of the questions below.*

**Do you feel you could benefit from installing grab bars on your tub and/or shower?**

- No
- Yes

**Do you use scatter rugs throughout your home?**

- No
- Yes

**Get dizzy or lightheaded when you change positions?**

- No
- Yes

**Problems walking for any reason?**

- No
- Yes



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**Vision Problems?**

- No
- Yes

**Do you use anything or anyone to help you walk?**

- No
- Yes

**CARE TEAM**

Please list all of the physicians that you are currently seeing (please include your eye care provider and any specialists):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

**DEPRESSION SCREENING**

Over the **past two weeks**, have you been bothered by any of the following problems? Please **circle** the answer in the column that best describes you.

	Not at all	Several days	More than half 7 days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in any way	0	1	2	3
How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

Interpreter Accepted \_\_\_\_\_  Interpreter Refused  
 (Name/Number of Person/Services Chosen/Used)



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