CalvertHealth Medical Group

CalvertHealth Primary Care
Medicare Wellness Visit

Patient Name: _____ DOB:_____ Date: _____

Health Risk Assessment (HRA)

Please circle the answers to each question below. Please complete and sign every page.

Self- assessment of Health Status, Frailty and Physical Functioning (ADLs & IADLs)				
1. How does your health compare to most people your age?	**Great**	**Good**	**Fair**	**Poor**
2. Do you have trouble dressing, bathing, eating, using the toilet or grooming?			**No**	**Yes**
3. Do you have trouble doing errands alone such as visiting your doctor or shopping?			**No**	**Yes**
4. Do you have trouble making food, doing housework, using phone or transportation?			**No**	**Yes**
5. Do you have trouble using your checkbook, paying bills or taking medicine?			**No**	**Yes**
6. Do you leak urine or soil your under clothes?			**No**	**Yes**
7. Do you have serious difficulty walking or climbing stairs?			**No**	**Yes**
8. Have you tripped or fallen during the last year?			**No**	**Yes**
9. Do you have trouble keeping your balance?			**No**	**Yes**
10. Are you deaf or do you have serious trouble hearing?			**No**	**Yes**
11. Are you legally blind or do you have serious trouble seeing, even if you wear glasses?			**No**	**Yes**
12. Do you exercise on a regular basis?			**No**	**Yes**
Psychosocial Risks				
13. Have you felt depressed, down, or hopeless in the last 14 days?			**No**	**Yes**
14. Have you lost pleasure in doing things you enjoy in the last 14 days?			**No**	**Yes**
15. Are you a victim of physical, sexual or emotional abuse?			**No**	**Yes**
16. Have you felt unusual pain or fatigue in the last 14 days?			**No**	**Yes**
17. Have you felt unusual stress, anger or loneliness in the last 14 days?			**No**	**Yes**
18. If you live with someone, is that person in good health?			**No**	**Yes**
19. Whom do you live with?	**Spouse/ Partner**	**Assisted/ Group Living**	**Friend/ Family**	**Alone**

Behavioral Risks (Social, Nutrition, & Safety)			
20. Do you drink alcohol, use tobacco or take illicit drugs?		**No**	**Yes**
21. Are you sexually active?		**No**	**Yes**
22. Do you frequently use sugar, salt or eat fatty or fried foods?		**No**	**Yes**
23. Do you frequently eat fruits, vegetables, fiber and whole grains?		**No**	**Yes**
24. Do you take calcium or vitamin supplements?		**No**	**Yes**
25. Have you seen a dentist during the last year?		**No**	**Yes**
26. Do you use a seat belt when riding in a vehicle?		**No**	**Yes**
27. Do you have any safety concerns at home?		**No**	**Yes**
Cognitive Impairment			
28. Are you or is someone close to you concerned about your memory?		**No**	**Yes**
29. Do you have trouble concentrating, remembering things or making decisions?		**No**	**Yes**
Providers & Suppliers			
30. Do you have other providers that give you care on a regular basis?		**No**	**Yes**
31. Does anyone else give you medical supplies on a regular basis?		**No**	**Yes**
32. Do you have a medical power of attorney/ advanced directive?	**No**	**Don't Know**	**Yes**

**Please sign **

Patient Signature **Date**

Medical Staff (Clinical Support or Provider) **Date**

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Please list all current physicians and specialty involved in your health care management:

Physician's Name	Specialty of Care

Please list all current medical supplies (i.e. respiratory aids, diabetes supplies, etc.):

Medical Supplies	Supplier	Supplier Contact Number

Please sign even if above lists are blank

Patient Signature **Date**

Provider Signature **Date**