HEALTH RISK ASSESSEMENT | The Annual Wellness Visit

Background Information

Medicare #: ____

First Name: ____________________ Last Name: __________________

Address: ____

City: ________________________ State: ___________ Zip: _______

Contact Phone: ______________ Email: _________________________

Gender: ☐ Male ☐ Female

Race: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian/Pacific Islander

☐ Native American ☐ Other

Date of Birth: _________ Age: _____ Primary Care MD: _______________

Preferred Contact Method:

☐ Email ☐ Text Message ☐ Phone Call ☐ U.S. Mail

Preferred Language____

Copyright © 2014 Vatica Health. All rights reserved.

Other Medical Providers

List all healthcare providers that are regularly provide you with medical care: Please use back if not enough space below to list all providers.

Medical Provider:	Type of Provider or Physician:

1____

2.____

3.____

4.____

Medications

☐Yes ☐ No Do you take aspirin on a daily basis?

List all your prescribed medications, over the counter medications, supplements including calcium and vitamins: Please use back if not enough space to list all medications.

Name	Dose:	Frequency:

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

9.____

10.____

Copyright © 2014 Vatica Health. All rights reserved.

Drug Allergies:

1.________________________ 2.______________________ 3.________________________

4.________________________ 5.______________________ 6.________________________

Lifestyle/Social History

☐ Yes ☐ No Do you eat a healthy balanced diet with minimal salt and bad fats?

(Example: Minimal Salts = Less than one teaspoon per day)
(Bad Fats = Fried Food, Fast Food, packaged foods from a box)

Smoking History

What is your history of smoking cigarettes?

☐ Current smoker ☐ Former smoker ☐ Never smoked

If yes, you smoke now or used to smoke, how many packs per day?

☐ Less than or Equal to One Pack

☐ More than One Pack, but less than or Equal to Two Packs

☐ More than Two Packs

If yes, you smoke now or used to smoke, how long have you (or did you) smoke cigarettes?

☐ Less than 10 years

☐ 10 - 20 Years

☐ More than 20 Years

☐ Yes ☐ No Do you currently use smokeless tobacco (chew, snuff)?

☐ Yes ☐ No Are you exposed to second hand smoke in the home?

Copyright © 2014 Vatica Health. All rights reserved.

Drug History

☐ Yes ☐ No — Are you now dependent or have you ever been dependent on any of the following drugs/medications Not For Medical Use:

- Cocaine
- Marijuana
- Amphetamines (Ex: Ritalin, Adderall)
- Sedatives/Anti-Depressants (Ex: Valium, Xanax, Effexor)
- Opiates (Ex: Oxycodone/Dilaudid/Heroine/Methadone)
- Hallucinogens
- Multiple Drugs
- Other

Alcohol History

Women:

☐ Yes ☐ No — Do you drink (7 or more alcoholic drinks per week or 3 OR more per episode of drinking?

Men:

☐ Yes ☐ No — Do you drink 14 or more alcoholic drinks per week OR 4 or more per episode (for men)?

Family History

Do you have a family history of any of the following medical conditions?
(Family history ONLY includes MOTHER, FATHER, SISTER, BROTHER, living or deceased)

☐ Yes ☐ No — Glaucoma

☐ Yes ☐ No — Diabetes

☐ Yes ☐ No — Coronary Artery (Heart) Disease

☐ Yes ☐ No — Colon Polyps

For the following, only answer "yes" if father/brother before the age of 55, or mother/sister before the age of 65:

☐ Yes ☐ No — Stroke, Transient Ischemic Attach/TIA or Mini Stroke

☐ Yes ☐ No — Breast Cancer (grandmother, mother or sister)

☐ Yes ☐ No — Colon Cancer (mother, father, sister, brother)

☐ Yes ☐ No — Prostate Cancer (father, brother)

☐ Yes ☐ No — Abdominal Aortic Aneurysm (parent/sibling)

Copyright © 2014 Vatica Health. All rights reserved.

Your Personal History of Medical Conditions:

Do you (not your family) have OR have you had any of the following conditions?

Glaucoma

☐ Yes ☐ No ☐ Unknown Glaucoma

High Blood Pressure

☐ Yes ☐ No ☐ Unknown High Blood Pressure

High Cholesterol

☐ Yes ☐ No ☐ Unknown High Cholesterol

Diabetes

☐ Yes ☐ No ☐ Unknown Diabetes

Kidney Disease

☐ Yes ☐ No ☐ Unknown Kidney Disease

Neurological Disorders

☐ Yes ☐ No ☐ Unknown

Do you have any of the following Neurological Disorders?
If yes, check all that apply

- ☐ Stroke/TIA/Mini Stroke
- ☐ Alzheimer's Disease
- ☐ Dementia

Heart and Lung Disorders

☐ Yes ☐ No ☐ Unknown

Do you have any of the following Heart problems?
If yes, check all that apply:

- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Heart Failure (Congestive Heart Failure or CHF)

Copyright © 2014 Vatica Health. All rights reserved.

☐ Heart Valve Disease
☐ Angina/Chest Pain
☐ Abnormal Heart Rhythm
☐ Atrial Fibrillation (A-Fib)/Atrial Flutter
☐ Taking Nitroglycerin

☐ Yes ☐ No ☐ Unknown

Do you have any of the following Lung Problems?
If yes, check all that apply:

☐ COPD/Chronic Obstructive Pulmonary Disorder
☐ Asthma

Gastrointestinal Disorders

☐ Yes ☐ No ☐ Unknown

Do you have any of the following Gastrointestinal Disorders? If yes, check all that apply:

☐ Crohn's Disease
☐ Ulcerative Colitis
☐ Hepatitis
☐ Colon Polyps
☐ Malabsorption Syndromes

Bone and Joint Disorders

☐ Yes ☐ No ☐ Unknown

Do you have any of the following Bone Problems?
If yes:

☐ Osteoporosis (Bone Disease/Weakening)
  ☐ If yes, Fracture from Osteoporosis

☐ Yes ☐ No ☐ Unknown

Do you have any of the following Joint Problems?

Degenerative Arthritis	Synovitis
Bursitis	Behcet's Arthritis
Osteoarthritis	Reiter's Arthritis

Copyright © 2014 Vatica Health. All rights reserved.

Cancer

☐ Yes ☐ No ☐ Unknown

Are you currently being treated, treated in the past year, or refused treatment for any of the following Cancers?

☐ Malignant

☐ Metastatic

If yes to Malignant or Metastatic Cancer, what type?

☐ Breast

☐ Colon/Rectum/Anus

☐ Cervix/Uterus/Vagina

☐ Prostate

Psychological Disorders

☐ Yes ☐ No ☐ Unknown

Do you have any of the following Psychological Disorders? If yes, check all that apply:

☐ Depression

☐ Bipolar Disorder

☐ Schizophrenia

☐ Anxiety

☐ Mood Disorder

☐ Unknown

☐ Depression Psychosis

☐ Paranoia

☐ Delusion

☐ Suicidal Behavior

☐ Other

☐ Yes ☐ No ☐ Unknown

Have you been to the dentist in last 12 months?

Surgical History

Have you had any of the following surgeries and/or medical procedures?

☐ Yes ☐ No ☐ Unknown

Heart Surgery/Heart Procedure

Copyright © 2014 Vatica Health. All rights reserved.

If yes, what type of Heart Surgery (Check all that Apply):

☐ Heart Valve Surgery ☐ Bypass Surgery

☐ Heart Procedure (stent) ☐ Pacemaker/ Defibrillator

If yes to Heart Surgery/Heart Procedure:

☐ Yes ☐ No ☐ Unknown Did you have cardiac rehabilitation after surgery?

☐ Yes ☐ No ☐ Unknown Did you have cardiac rehab after angioplasty?

For Women:

☐ Yes ☐ No ☐ Unknown Have you ever had an abnormal pap smear?

Review of Symptoms

General

☐ Yes ☐ No Have you had any unintentional weight loss in the past 6 months?

If so, what is the amount of your recent weight loss: ___________ lbs

☐ Yes ☐ No Do you have increasing or worsening weakness or tiredness that is new to you within the last year?

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

☐ Not at all ☐ A little bit ☐ Moderate ☐ Quite a bit ☐ Extreme

Vision

☐ Yes ☐ No Have you had any recent changes in your vision?

Respiratory/Pulmonary (Lungs)

☐ Yes ☐ No Have you recently had trouble breathing?

☐ Yes ☐ No Do you have a persistent cough that will not go away?

Copyright © 2014 Vatica Health. All rights reserved.

Cardiac (Heart)

☐ Yes ☐ No Do you ever have chest pain, tightness or heaviness in your chest?

☐ Yes ☐ No Do you ever feel short of breath with daily activities such as dressing, showering/bathing, doing laundry, shopping, or walking?

☐ Yes ☐ No Do you have difficulty breathing when lying down flat?

☐ Yes ☐ No Do your legs swell?

☐ Yes ☐ No Do you wake up at night feeling smothering, unable to breathe or drowning that causes you to sit upright?

Vascular (Arteries, Veins)

☐ Yes ☐ No Do you have numbness/tingling in your arms or legs?

☐ Yes ☐ No When walking, do you ever have pain in the back of your legs (calves) that interferes with your lifestyle (example: not able to exercise, not able to walk)?"

☐ Yes ☐ No Do you have pain in your legs that gets more sever when your legs are elevated and the pain diminishes when your legs are in a dependent position (example sitting on bed with legs dangling)?

Musculoskeletal (Muscles, Bones, Tendons, Ligaments)

☐ Yes ☐ No Do you have increasing or worsening pain in your joints that is new to you within the last year? (back, neck, hips, knees, shoulders or hands)

Bladder

☐ Yes ☐ No Many people experience problems with urinary incontinence, the leakage of urine. In the past 6 months, have you accidentally leaked urine?

If yes, how much of a problem was the urine leakage for you?

☐ A big problem ☐ A small problem ☐ Not a problem

Copyright © 2014 Vatica Health. All rights reserved.

Tests/Therapies

Have you had any of the following test and/or therapies?	Date If Known
☐ Yes ☐ No Cholesterol Profile within the last 5 years? If yes, please complete, if known Total Cholesterol:______ HDL:______ LDL:______ Triglycerides:______	
☐ Yes ☐ No Program to Quit Smoking within the last six months?	
☐ Yes ☐ No Colonoscopy in the last 10 years?	
☐ Yes ☐ No Mammogram within the last 27 months?	
☐ Yes ☐ No Flu Shot Vaccine within the current flu season?	
☐ Yes ☐ No Pneumococcal Vaccine within the last 5 years?	
☐ Yes ☐ No Stool Occult Blood within last year?	
☐ Yes ☐ No Bone Densitometer within the last 2 years?	
☐ Yes ☐ No Abdominal Ultrasound for Aneurysm in your lifetime?	
☐ Yes ☐ No Test for Glaucoma within the last year?	
☐ Yes ☐ No Blood Sugar Test (Glucose) within the last year? Glucose Value: ☐ 70 - 100 ☐ 101 - 126 ☐ More than 126 HgBA1C Value: ☐ < 7% ☐ 7-9% ☐ > 9%	
☐ Yes ☐ No (Male) PSA (Prostate) Blood Test within the last year?	
☐ Yes ☐ No Hepatitis B Vaccine ever in your lifetime?	
☐ Yes ☐ No HIV Screening within the last year?	
☐ Yes ☐ No (Female) Pap Smear/Pelvic Exam within last 2 years?	
☐ Yes ☐ No Echocardiogram	
☐ Yes ☐ No Chest X-ray	
☐ Yes ☐ No Serum Albumin	

Copyright © 2014 Vatica Health. All rights reserved.

Self-Assessment

Considering your age, how would you describe your overall health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

How much difficulty, if any, do you have walking a ¼ mile which is about 2 or 3 blocks?

- ☐ No difficulty at all
- ☐ A little difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Not able to do it

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

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Depression Assessment

☐ Yes	☐ No	Over the past 2 weeks, have you felt down, depressed, or hopeless?
☐ Yes	☐ No	Over the past 2 weeks, have you felt little interest or pleasure in doing things?

Self-Change Modifications

In the next 6 months, are you willing to make the following changes to improve your health?

☐ Yes	☐ No	Increase Physical Activity/Exercise
☐ Yes	☐ No	Lose Weight
☐ Yes	☐ No	Reduce Alcohol Use
☐ Yes	☐ No	Improve Diet
☐ Yes	☐ No	Reduce Stress
☐ Yes	☐ No	Quit Smoking
☐ Yes	☐ No	Improve Sleep Habits

Copyright © 2014 Vatica Health. All rights reserved.

Fall Risk & Home Safety

☐ Yes ☐ No Do you always fasten your seat belt when you are in a car?

☐ Yes ☐ No Do you have any problems with your hearing?

☐ Yes ☐ No Do you have a problem with balance?

☐ Yes ☐ No Do you have a problem walking?

☐ Yes ☐ No A fall is when your body goes to the ground without being pushed. Have you fallen in the past 12 months?

If Yes to Fall:

☐ Yes ☐ No Were you injured from the fall?

☐ Yes ☐ No Have you had more than one fall?

Activities of Daily Living Scale

☐ Yes ☐ No In the past 7 days, did you need help to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, getting in or out of bed or a chair, or using the toilet?

If yes, check all that apply:

☐ Eating ☐ Getting dressed
☐ Bathing ☐ Walking
☐ Getting in and out of bed/chair
☐ Using the toilet

☐ Yes ☐ No In 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 medications?

Copyright © 2014 Vatica Health. All rights reserved.

Biometrics (This Page for Provider Use Only)

General

Medical Record #: ____________________ MA Plan: ____________________________

Height: ________________ Weight: ________________ BMI: ___________________

Blood Pressure: __________ / __________ Visit Date: _______________

Gait Evaluation

☐ Yes ☐ No Normal Gait Observed?

Welcome to Medicare Visit (IPPE)

Visual Acuity: L:20/__________ R:20/__________

☐ Yes ☐ No Corrective Lens Used?

End of Life Planning?

☐ Yes ☐ No Will the patient consent to an End of Life Planning discussion?

Comments: ____

____

____

Cognitive Assessment

Number of items recalled (APPLE, WATCH, PENNY): ☐ 0 ☐ 1 ☐ 2 ☐ 3

Clock Drawing Test: ☐ Abnormal ☐ Normal

Comments: ____

____

____

Thank You! You have completed the Health Risk

Copyright © 2014 Vatica Health. All rights reserved.