Medicare Wellness Visit: Health Risk Assessment

SANTA MONICA FAMILY PHYSICIANS

Patient's Name: _____ **Date of Birth:** _____

GENERAL HEALTH:				
How would you describe your current health? (please circle)	Excellent	Good	Fair	Poor
			YES	**NO**
Have you had a dental exam in the last year?				
Do you drive a car?				
Do you wear a seatbelt 100% of the time?				
Comment:				

HEARING SCREEN:	**YES**	**NO**
Do you wear hearing aids?		
Do you have trouble hearing the television or radio when others do not?		
Do you have to strain or struggle to hear or understand conversation?		

FUNCTIONAL SCREEN:	**YES**	**NO**
Do you need help with dressing yourself, eating, voiding, toileting, or bathing?		
Do you need help transferring yourself from seated to standing position, or getting in and out of bed?		
Do you need help with any of the following: shopping, housekeeping, managing your own medications, or handling your finances?		
Do you live alone?		
If not, who do you live with?		
Comments:		

HOME SAFETY / RISK FOR FALLS SCREEN:	**YES**	**NO**
Are there any non-slip mats in all bathtubs and showers?		
Does your home have grab bars in bathrooms and handrails on stairs/steps?		
Have throw rugs been removed or fastened down?		
Have you fallen in the past 6 months?		
Do you ever feel like you might lose your balance?		
Comments:		

HAVE YOU COMPLETED AN ADVANCE CARE DIRECTIVE and/or POLST?	**YES**	**NO**