Annual Wellness Visit (AWV) HRA (Health Risk Assessment)

NAME _____ **DOB:**_____

1. During the past year, how would you rate your health in general?

Excellent | Very good | Good | Fair | Poor

2. How confident are you that you can control and manage most of your health problems and take medicines the way you have been told to take them?

Very confident | Somewhat confident | Not very confident

3. During the past two weeks, has your physical and/or emotional health limited your social activities with family friends, neighbors, or groups?

Not at all | Several Days | More than ½ the days | Nearly everyday

4. During the past two weeks, how often have you been bothered by emotional problems like feeling anxious, depressed, irritable, sad, downhearted or blue?

Not at all | Several Days | More than ½ the days | Nearly everyday

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

Not at all | Several Days | More than ½ the days | Nearly everyday

6. 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?

Not at all | Several Days | More than ½ the days | Nearly everyday

7. Because of any **health problems**, do you need the help of another person with your personal finances, running errands including grocery shopping, driving?

Not at all | Several Days | More than ½ the days | Nearly everyday

8. Have you fallen or almost fallen or were afraid of falling at anytime in the past year?

Not at all | 1-2 times | 3-6 time. | Nearly everyday

9. Does your home have SAFETY HAZARDS (rugs in the hallway, lack of grab bars in the bathroom, lack handrails on the stairs or have poor lighting? (underline any items of note and select yes/no below)

- YES
- NO

10. Do you have any hearing difficulties and/or use hearing aids?

- YES
- NO

11. Do you have a Living Will or Advance Directive for healthcare or a POLST (physician's order of Life sustaining Treatment)?

- YES
- NO

12. You Identify with the following RACE (check any/all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

13. You Identify with the following ETHNICITY (check ONLY one)

- Hispanic or Latino
- Not Hispanic or Latino

14. Your preferred LANGUAGE

- English
- Other _____

15. Please list any known diagnosis/ medical conditions that concern you

16. List the doctors or healthcare providers (Such as Physical Therapist/ Counselor/ Oxygen Supplier) that you see for your health needs

Specialty (for what healthcare needs)	Name of Doctor or Office

Details about Recommended Screening tests

Test Name	Year of test	Place of test (facility or Doctors name)
Colonoscopy		
Eye Exam		
Bone Density		
Mammogram (women)		
Pelvic Exam (women)		
Prostate (men)		

Details about Recommended Vaccination

Vaccine Name	Year of Shot	Injection place (facility or Doctors name)
Flu (Influenza)		
Pneumonia/Pneumococcal (Pneumovax)		
Pneumonia/Pneumococcal (Prevnar 13)		
Shingles (Herpes Zoster)		
Tetanus, Diphtheria, Pertussis (Tdap)		

Details about your Lifestyle Choices/ Health Habits

Activity	Yes/No	Details (How much, how often)
Smoking or Smokeless Tobacco use ever		Past only /current :
Alcohol Use ever		Past only /current :
Other " recreational" drug use ever		Past only /current
Caffeinated drinks use regularly		Cups or Cans /day
Regular Activity or Exercises		Minutes/ day

Details about your Family History

- ☐ Check Here if you are adopted and/or DO NOT know

Relationship	Health Problems	Age of Death (if applicable)
Father		
Mother		
Brothers		
Sisters		
Son		
Daughters		