Einstein HEALTHCARE NETWORK

Name: _____DOB: ____/___/_____

MR: _____FIN: _____

ANNUAL WELLNESS VISIT - HEALTH RISK ASSESSMENT(HRA)

Dear _____,

Your Appointment for the ❑Welcome to Medicare Visit ***OR*** ❑Annual Wellness Visit is scheduled

on_____ at _____.

There is **NO CO-PAY** for this visit, so it is free for you!

The goal of this visit is to provide time for you to discuss with our health care team, areas of your health that may put you at risk for problems and to help you and your provider better understand what screenings you should get in the future.

At your wellness visit, we will take a complete health history and provide several other services:

- Screenings to detect depression, risk for falling and other problems,
- A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity,
- A screening schedule for appropriate preventive services will be developed
- Risk factors and treatment options will be reviewed and recommended

This is **NOT** a "Problem Visit and **WILL NOT** include treatment or management of problems.

So that your provider has all necessary information, **please complete ALL of the enclosed forms and bring them with you to your visit.**

If you arrive at the office without these forms, your visit may need to be rescheduled.

Please make sure to be on time and call with more than 24 hours' notice if you cannot make your appointment.

We look forward to seeing you soon!

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Please complete the entire questionnaire as thoroughly as possible so that your provider has a complete and up to date history. This confidential history will be part of your permanent medical record

Please list all providers and suppliers of your medical care such as primary care physicians, specialty physicians, chiropractors, pharmacies, herbalists and therapists.

Primary Care Physician(s)	**Specialty**
Other Providers:	**Specialty**

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Current Medications:

Please include prescriptions, over-the counter medications, Vitamins, Herbs, and Supplements

Medication name	Dose	Frequency	Route

DAILY ASPIRIN USE	
Have you discussed taking a daily aspirin with your doctor?	❑Yes ❑No ❑ I don't know ❑I already take a daily aspirin

Medication Allergies:

Medication	Reaction

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Medical History: Please check the appropriate box for the conditions as they apply to you.

Condition	Yes	No	Comments		Condition	Yes	No	Comments		Condition	Yes	No	Comments
Allergies					Depression					Heart Attack (Myocardial infarction)			
Anemia					Diabetes					Nerve/muscle disease			
Anxiety					Emphysema					Osteoporosis			
Arthritis					Reflux, Heartburn (GERD)					Seizures			
Asthma					Glaucoma					Sickle cell anemia			
Blood transfusion					Heart murmur					Stroke			
Cancer					HIV/AIDS					Substance abuse			
Cataracts					High Blood Pressure (Hypertension)					Thyroid disease			
Heart Failure (CHF)					Kidney disease					Tuberculosis			
Clotting disorder					Meningitis					Ulcers			
Chronic obstructive lung disease (COPD)													

Other Medical History:

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Surgical History: Female

Surgery	Yes	No	Comments		Surgery	Yes	No	Comments		Surgery	Yes	No	Comments
Appendectomy					Cosmetic surgery					Joint replacement			
Brain surgery					C-Section					Small intestine surgery			
Breast Surgery					Eye surgery					Spine surgery			
Gall Bladder Surgery (Cholecystectomy)					Fracture surgery					Tubal Ligation			
Colon surgery					Hernia repair					Heart Valve Replacement			

Surgical History: Male

Surgery	Yes	No	Comments		Surgery	Yes	No	Comments		Surgery	Yes	No	Comments
Appendectomy					Cosmetic surgery					Prostate surgery			
Brain surgery					Eye surgery					Small intestine surgery			
Heart Bypass					Fracture surgery					Spine surgery			
Gall Bladder Surgery (Cholecystectomy)					Hernia repair					Heart Valve Replacement			
Colon surgery					Joint replacement					Vasectomy			

Other Surgical History:

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Family History: Please check the appropriate box of the conditions that apply to <u>your blood relatives</u>:

Relation	Alive	Deceased	Alcohol abuse	Arthritis	Asthma	Birth Defects	Cancer	Chronic Obstructive	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Learning Disability	Mental illness	Mental Retardation	Miscarriages	Stroke	Vision loss
Mother																							
Father																							
Sister																							
Brother																							
Daughter																							
Son																							

Social History	
Alcohol Use: How many times in the past year have you had 4 or more drinks in a day?	❑None ❑1-2 ❑3-4 ❑5+ ❑I don't drink alcohol
Tobacco Use: Do you use any type of tobacco products?	❑Yes ❑No **If Yes:** Complete the information below:
❑Cigarettes ❑Chew ❑Cigars ❑Pipe ❑Snuff ❑Smokeless Tobacco (Vape) ❑Current Every Day Smoker? _____ Number of packs per day _____ Number of Years ❑Current Smoker? (not daily) _____ Number of packs per week _____ Number of Years ❑Former Smoker? Quit date _____ ❑Passive Smoker (2nd hand/inhalation of smoke)?	
Are you interested in quitting tobacco?	❑Yes ❑ No ❑I don't use tobacco
Are you interested in receiving help for any other type of substance abuse?	❑Yes ❑ No ❑I don't use other substances

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PHYSICAL ACTIVITY	
How many days a week do you usually exercise?	❑None ❑1-2 ❑3-4 ❑5+ ❑I don't know
On days when you exercise, for how long do you usually exercise?	❑0-30 ❑30 min to1 hour ❑More than 1 hour ❑I don't know ❑I am currently not exercising
How intense is your typical exercise? (Check one)	❑ Light (like stretching or slow walking) ❑ Moderate (like brisk walking) ❑ Heavy (like jogging or swimming) ❑ Very heavy (like fast running or stair climbing) ❑ I am currently not exercising
NUTRITION	
How many servings of fruits and vegetables do you have in a day	❑None ❑1-2 ❑3-4 ❑5+ ❑I don't know
How many servings of meat, fish or other proteins do you have in a day?	❑None ❑1-2 ❑3-4 ❑5+ ❑I don't know
How many servings of fiber or whole grains do you have in a day?	❑None ❑1-2 ❑3-4 ❑5+ ❑I don't know
How many servings of fried or high-fats foods do you have in a day?	❑None ❑1-2 ❑3-4 ❑5+ ❑I don't know
How many servings of sugar sweetened drinks do you have in a day?	❑None ❑1-2 ❑3-4 ❑5+ ❑I don't know

ORAL HEALTH	
How is the health of your mouth and teeth?	❑ Excellent ❑Good ❑Fair ❑Poor ❑I don't know
Do you visit the dentist regularly?	❑ Yes ❑No ❑ I don't know

MOTOR VEHICLE SAFETY			
Do you always fasten your seat belt when you are in the car?	❑Yes	❑No	❑ I do not drive
Do you ever drive after drinking, or ride with a driver who has been drinking?	❑Yes	❑No	❑ I do not drive

SUN EXPOSURE			
Do you protect yourself from the sun when you are outdoors?	❑Yes	❑No	❑Sometimes

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DEPRESSION SCREENING (PHQ9) Circle your answer's

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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
☐	☐	☐	☐

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GENERAL WELL-BEING					
In general, would you say your health is?	❑Excellent	❑Very good	❑Good	❑Fair	❑Poor
Do you take all your medications as prescribed?	❑Yes	❑No	❑Sometimes	❑Almost Never	❑I don't take medication
In the last six months, how many times were you admitted to the hospital?	❑ 0	❑1-2	❑3-4	❑5+	❑I don't know
In the last six months, how many times have you been to the emergency room?	❑ 0	❑1-2	❑3-4	❑5+	❑I don't know

SOCIAL/EMOTIONAL SUPPORT					
How often do you get the social and emotional support you need?	❑Always	❑Usually	❑Sometimes	❑Rarely	❑Never

STRESS/ANGER				
How often is stress/anger a problem for you?	❑Never, rarely	❑Sometimes	❑Often	❑Always
How well do you handle the stress/anger in your life?	❑I'm usually able to cope effectively	❑At times I have problems coping	❑I often have problems coping	

PAIN/FATIGUE				
How often do you feel unusually tired?	❑Never, rarely	❑Sometimes	❑Often	❑Always
Do you have pain that interferes with performing desired activities?	❑Never, rarely	❑Sometimes	❑Often	❑Always

SLEEP	
How many hours of sleep do you usually get?	❑0-3 ❑4-6 ❑7-10 ❑10+ ❑I don't know
Do you snore or has anyone told you that you snore?	❑Yes ❑ No ❑ I don't know
In the past 7 days, how often have you felt sleepy during the daytime?	❑Often ❑Sometimes ❑Almost never ❑Never ❑ I don't know

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FUNCTIONAL ABILITY ASSESSMENT	
Instrumental activities of daily living	
Which of the following can you do on your own?	❑Shop for groceries ❑Use the telephone ❑Housework ❑Handle finances ❑Drive/use public transportation ❑Make meals ❑Take medications ❑None
Activities of daily living	
Which of the following can you do on without help?	❑Bath ❑Walk ❑Dress ❑Eat ❑Transfer in/out of chair, etc ❑Use the restroom ❑None
Many experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experience leakage of urine?	❑Yes ❑ No ❑I don't know
Ambulation Status	
How long can you walk or move around?	❑0-5 ❑5-15 ❑15-30 ❑More than 1 hour ❑ I don't know
Do you feel unsteady when standing or walking?	❑Yes ❑ No ❑Sometimes ❑ I don't know
Which of these assistive devices do you use?	❑Cane ❑Walker ❑Wheelchair ❑Crutches ❑Other ❑None
Do you feel dizzy when you get up from a bed or chair?	❑Yes ❑ No ❑Sometimes ❑ I don't know
Are you afraid to leave the house alone due to dizziness or imbalance problems?	❑Yes ❑ No ❑Sometimes ❑ I don't know
Fall Risk Assessment	
Have you fallen in the past year?	❑Yes ❑ No ❑I don't know
How many times have you fallen in the past year?	❑1-2 ❑3-4 ❑5+ ❑ I don't know ❑ I did not fall
Do you worry about falling?	❑Yes ❑ No ❑Sometimes

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HEARING SCREENING	
Do you have a problem with hearing?	❑ Yes ❑ No ❑ I don't know
Do you use hearing aids or other devices to help you hear?	❑ Yes ❑ No ❑ I don't know
Do you have a problem hearing the telephone?	❑ Yes ❑ No ❑ I don't know
Do you have trouble hearing the television or radio	❑ Yes ❑ No ❑ I don't know
Do people complain that you turn the TV volume up too high?	❑ Yes ❑ No ❑ I don't know
Do many people you talk to seem to mumble (or not speak clearly)?	❑ Yes ❑ No ❑ I don't know
Do you find yourself asking people to repeat themselves?	❑ Yes ❑ No ❑ I don't know
Do you have trouble hearing in a noisy background?	❑ Yes ❑ No ❑ I don't know
VISION SCREENING	
Do you have problems with your vision?	❑ Yes ❑ No ❑ I don't know
Do you wear contact lenses or eyeglasses?	❑ Yes ❑ No ❑ Sometimes
HOME SAFETY	
What is your living situation	❑Alone ❑With my spouse or other family with a friend or roommate ❑ In nursing home or assisted living facility/home ❑ I don't have a place to live ❑ Other
Does your home have rugs in the hallways?	❑Yes ❑No ❑ I don't know
Does your home have grab bars in the bathroom?	❑Yes ❑No ❑ I don't know
Is there any clutter in your walking space at home?	❑Yes ❑No ❑ I don't know
Does your home have functioning smoke alarms?	❑Yes ❑No ❑ I don't know
Does your home have handrails on stairs and steps?	❑Yes ❑No ❑ I don't know

MEMORY LOSS	
Have you experienced any memory issues or problems with thinking?	❑Yes ❑No ❑ I don't know
Do family members report that you have difficulty remembering things?	❑Yes ❑No ❑ I don't know

END OF LIFE PLANNING	
Do you have an Advance Directive, Living Will or Power of Attorney for Health Care (POA), in the case that an injury or illness causes you to be unable to make healthcare decisions?	❑Yes ❑No ❑ I don't know
Would you like further information regarding Advance Directives?	❑Yes ❑No ❑ I already have one

OFFICIAL USE ONLY		
HRA Reviewed by:	Clinician Name(Print):	Date:
	Clinician Signature:	