SIH
Southern Illinois Medical Services

CSN MRN

Medicare Annual Visit Health Risk Assessment

Patient Name _____ **Date of Birth** _____

Today's Date _____ **Provider** _____

During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Quite a bit
- ○ Extremely

During the **past four weeks**, how much bodily pain have you generally had?

- ○ No pain
- ○ Very mild pain
- ○ Mild pain
- ○ Moderate pain
- ○ Severe pain

Do you have any questions or are you having any issues with the medication you are taking?

- ○ Yes
- ○ No

During the **past four weeks**, was someone available to help you if you needed and wanted help?
(For example, if you felt very nervous, lonely, or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.)

- ○ Yes, as much as I wanted
- ○ Yes, quite a bit
- ○ Yes, some
- ○ Yes, a little
- ○ No, not at all

Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)

- ○ Yes
- ○ No

Can you go shopping for groceries or clothes without someone's help?

- ○ Yes
- ○ No

Can you prepare your own meals?

- ○ Yes
- ○ No

Can you do your own housework without help?

- ○ Yes
- ○ No

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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?

- ○ Yes
- ○ No

Can you handle your own money without help?

- ○ Yes
- ○ No

During the **past four weeks**, how would you rate your health in general?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

Do you always fasten your seatbelt when you are in a car?

- ○ Yes, usually
- ○ Yes, sometimes
- ○ No

How often during the **past four weeks**, have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often
Falling or dizzy when standing up				
Sexual problems				
Teeth or denture problems				
Problems using the telephone				
Tiredness or fatigue				

Have you fallen two or more times in **the past year?**

- ○ Yes
- ○ No

Are you afraid of falling?

- ○ Yes
- ○ No

Do you exercise for about 20 minutes three or more times a week?

- ○ Yes, most of the time
- ○ Yes, some of the time
- ○ No, I usually do not exercise this much

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How often do you have trouble taking medicines the way you have been told to take them?

- I do not have to take medicine
- I always take them as prescribed
- I sometimes take them as prescribed
- I seldom take them as prescribed

How confident are you that you can control and manage most of your health problems?

- Very confident
- Somewhat confident
- Not very confident
- I do not have any health problems

Are you having any issues receiving needed services such as an appointment with a specialist, a referral etc?

- No
- Yes. If so, what type of appointment _____

Have you been bothered by feeing down, uninterested in social events or anxious?

- Yes, most of the time
- Yes, some of the time
- No, I usually enjoy social events and spending time along with others

How often has your level of energy interfered with your social and/or physical activities?

- Never
- Once or twice a week
- Many times a week

Have you had any problems controlling your bladder in the past six months?

- No
- Yes, as often as _____weekly
  Symptoms are worse
  - With activity
  - At night

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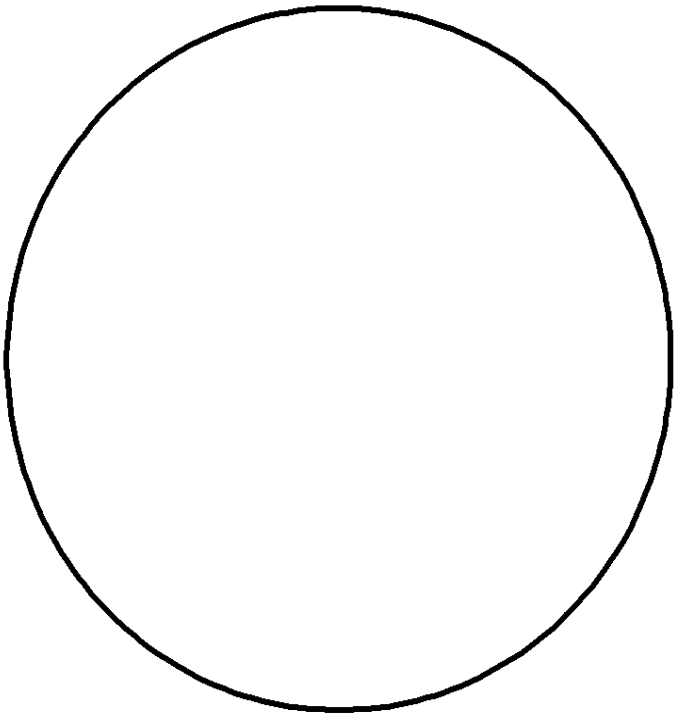
Clock Drawing Test

1) Inside the circle, please draw the hours of a clock as they normally appear

2) Place the hands of the clock to represent the time: "ten minutes after eleven o'clock"



_____ _____ _____
Signature of Patient (or Legal Representative) Date Time

_____ _____
Printed Name of Legal Representative Relationship to Patient