Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

Medicare Health Risk Assessment

To reproduce, follow the printing instructions. Do not fold this form.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

CURRENT HEALTH CONDITIONS

What health conditions do you currently have? *(Please mark each condition that applies to you.)*

- heart disease
- breathing problems caused by emphysema or asthma
- diabetes or other blood sugar problems
- other conditions
- heart failure or an enlarged heart
- kidney dialysis
- depression
- **NONE**

PRESCRIPTION DRUGS

How many different prescription drugs do you take each day?

0	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20 or more

GENERAL HEALTH

We want to know how easy or difficult it is for you to get around.

Do you have any trouble getting around?	yes	no
Do you use a cane, wheelchair or walker to move around?	yes	no
Do you need the help of another person to move around?	yes	no
Do you need to stay in the house most or all of the time?	yes	no
Do you need to stay in bed most or all of the time?	yes	no
Do you have any recent dietary changes?	yes	no
Have you had any recent injuries?	yes	no

HELP AT HOME

Do you need help at home due to your health problems?	yes	no
Has it been hard for you to get the help you need?	yes	no

HOSPITAL STAYS IN THE LAST YEAR

In the previous 12 months, have you stayed overnight as a patient in the hospital?	yes	no	
About how many times?	1 time	2 – 3 times	4 or more times

MEMORY LOSS

Are you being treated for serious memory loss or have you been told you have serious memory loss?	yes	no

DEPRESSION

During the past month, have you been bothered by:

Feeling down, depressed or sad?	yes	no
Little interest or pleasure in doing things?	yes	no