Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Medicare Health Risk Assessment

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

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

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

Do you take any prescription drugs? yes no

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 hard it is for you to get around.

Do you have any trouble getting around at home or outside your home? yes no
Do you use a cane, wheelchair or walker to move around at home or outside your home? yes no
Do you need the help of another person to move around inside or outside your home? 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

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