

Health Risk Assessment Questionnaire

Office Use Unity: Medicare Wellness Visit	☐ Welcome to Medicare Visit
Namo	Date of Birth:
Name:	
In general, would you say your health is?	Do you know where to locate and properly use a first aid kit and fire extinguisher in case of an emergency?
☐ Excellent	☐ Yes
Good	□ No
□ Fair	In the past 7 days, did you need help from others to perform
☐ Poor	everyday activities such as eating, getting dressed, grooming,
In general, how satisfied are you with your life?	bathing, walking, or using the toilet?
☐ Very satisfied	☐ Yes
☐ Satisfied	□ No
☐ Dissatisfied☐ Very Dissatisfied	In the past 7 days, did you need help from others to take care
•	of things such as laundry and housekeeping, banking,
In the past 7 days, how much pain have you felt?	shopping, using the telephone, food preparation,
□ None	transportation, or taking your own medications?
□ Some	☐ Yes
☐ A lot	□ No
Do you usually exercise at least 30 minutes or more, 5 days a week?	In the past 7 days have you had any problems staying or falling asleep?
☐ Yes	☐ Yes
□ No	□ No
Do you usually eat a diet that has at least 4 servings of fruit &	In the past 7 days have you had problems with constipation?
vegetables, includes whole grain & fiber and avoids other than occasional servings of high fat foods?	☐ Yes
	□ No
☐ Yes	In the past year have you had:
□ No	☐ 2 or more falls or a fall with an injury
How would you describe the condition of your mouth and teeth (including false teeth or dentures)?	☐ No falls or 1 fall with no injury
□ Excellent	Does your home have rugs in the hallway?
☐ Good	☐ Yes
□ Poor	□ No
In a typical week, how much alcohol do you drink?	Does your home have grab bars in the bathroom?
□ None	□ Yes
☐ One drink per day or less	□ No
☐ Two drinks per day	Does your home have handrails on the stairs?
☐ More than 2 drinks per day	□ Yes
Do you ever have 5 or more alcoholic drinks on one occasion?	□ No
, □ Yes	Does your home have good lighting?
□ No	□ Yes
Do you always fasten your seat belt when you are in the car?	□ No
☐ Yes	
□ No	
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HRA Template 1



Health Risk Assessment Questionnaire

Do you or any of your friends or family members have any concerns about your memory?	
□ Yes	
□ No	
Do you have any problems with your hearing?	
□ Yes	
□ No	

HRA Template 2