Annual Wellness Visit
Health Risk Assessment (HRA)

Patient Label

Falls Risk Questionnaire

1	Have you tripped or fallen during the last year?	No ☐	Yes ☐
2	Do you have trouble keeping your balance?	No ☐	Yes ☐

Self-assessment of Health Status, Frailty, and Physical Functioning (ADLs & IADLs)

3	How does your health compare to most people your age?	Great ☐	Good ☐	Fair ☐	Poor ☐
4	Do you need help with dressing, bathing, eating, using the toilet, or grooming?	No ☐	Yes ☐		
5a	In the past year, has lack of transportation kept you from medical appointments or from getting medications?	No ☐	Yes ☐		
5b	In the past year, has lack of transportation kept you from meetings, work, or getting things needed for daily living?	No ☐	Yes ☐		
6	Do you need help making food or doing housework?	No ☐	Yes ☐		
7	Do you have trouble managing your money or your medications?	No ☐	Yes ☐		
8a	Do you leak urine?	No ☐	Yes ☐		
8b	Do you leak stool or lose control of your bowels?	No ☐	Yes ☐		
9	Do you have serious difficulty walking or climbing stairs?	No ☐	Yes ☐		
10	Are you deaf or do you have serious trouble hearing?	No ☐	Yes ☐		
11	Are you legally blind or do you have serious trouble seeing, even if you wear glasses?	No ☐	Yes ☐		
12a	On average, how many days per week do you engage in moderate to strenuous exercise? (like a brisk walk?) *(please circle the number of days)*	0 1 2 3 4 5 6 7			
12b	On average, how many minutes do you engage in exercise at this level?	None ☐	1-30 minutes ☐	31-60 minutes ☐	Over 60 minutes ☐

Cognitive Impairment

13	Do you have new memory problems in the past year?	No ☐	Yes ☐
14	Do you have trouble thinking clearly or making decisions?	No ☐	Yes ☐

Providers & Advance Directive

15	Have you seen other providers in the past year?	No ☐	Yes ☐	
16	Do you have a medical power of attorney/advance directive?	Yes ☐	Don't Know ☐	No ☐

Medical Supplies

17 Which of these medical supplies do you use?

None ☐ Oxygen ☐ CPAP supplies ☐ Cane, walker or wheelchair ☐ Ostomy supplies ☐ Other ☐

Additional Systems

18	Have you unintentionally lost weight in the past year?	No ☐	Yes ☐
19	In the past 2 weeks, have you had more pain than usual?	No ☐	Yes ☐
20	In the past 2 weeks, have you had more fatigue than usual?	No ☐	Yes ☐
21	In the past 2 weeks, have you had more trouble breathing than usual?	No ☐	Yes ☐
22	In the past 2 weeks, has your appetite or bowel function changed?	No ☐	Yes ☐
23	In the past 2 weeks have you experienced unexplained lightheadedness or dizziness?	No ☐	Yes ☐

Please continue to questions 24-36 on page 2

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Psychosocial & Safety Risks

PHQ-2: Over the last 2 weeks, how often have you been bothered by any of the following problems?

24	Little interest or pleasure in doing things?	Not at All ☐	Several days ☐	More than half the days ☐	Nearly every day ☐
25	Feeling down, depressed, or hopeless?	Not at All ☐	Several days ☐	More than half the days ☐	Nearly every day ☐
26a	Within the last year, have you been afraid of your partner or ex-partner?	Yes ☐	No ☐
26b	Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	Yes ☐	No ☐
26c	Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?	Yes ☐	No ☐
27	Do you feel safe at home?	Yes ☐	No ☐
28	Are you a caregiver for another person?	No ☐	Yes ☐
29	In a typical week, how many times do you talk on the phone with family, friends, or neighbors?	Never ☐	Once /week ☐	Twice /week ☐	Three /week ☐	More than three /week ☐
30	Whom do you live with?	Spouse/Partner ☐	Assisted/Group Living ☐	Friend/Family ☐	Alone ☐

Behavioral Risks (Social, Nutrition, & Safety)

31a	How often do you have a drink containing alcohol?	Never ☐	One per month ☐	2 to 4 monthly ☐	2 to 3 weekly ☐	4 or more weekly ☐
31b	How often do you have six or more drinks in one occasion?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Almost daily ☐
31c	Do you use recreational drugs or prescription medications for non-medical reasons?	Never ☐	Not in past year ☐	Yes ☐
31d	Tobacco Use	Never ☐	Former Use ☐	Yes ☐
32a	Are you sexually active?	No ☐	Yes ☐
32b	With whom have you had sex?	Men ☐	Women ☐	Both ☐	Other ☐
33	Do you think your diet is unhealthy?	No ☐	Yes ☐
34	Do you take herbal or vitamin supplements that are not on your medication list?	No ☐	Yes ☐
35	Have you been to a dentist during the last year?	Yes ☐	No ☐
36	Do you use a seat belt when riding in a vehicle?	Yes ☐	No ☐

Patient's Signature: Date:

Medical Staff Initials (Clinical Support or Provider): Date: