CFM CLEARWATER FAMILY MEDICINE
a division of Arcturus Healthcare PLC

Medicare Health Risk Assessment

Name: _____ **Date:** _____

1.During the past two weeks, have you felt down, depressed, anxious, irritable or hopeless?
___ **Not at all** ___**Several Days** ___**Most days** ____**Everyday**

2.During the past two weeks how often have you been bothered by having little interest or pleasure in doing things?
___**Not at all** ___**Several Days** ___**Most Days** ____**Everyday**

3.During the past four weeks, has your physical or emotional health limited your social activities with family or friends? ___ **Yes** ___ **No**

4.Can you get to places of walking distance without help? (For example, can you travel alone on buses or a taxi, or drive your own car?) ___ **Yes** ___**No**

5.Can you go shopping for groceries or clothes without someone's help? ___**Yes** ___**No**

6.Can you do your housework without help? ___**Yes** ___**No**

7.Can you handle your own money without help? ___**Yes** ___**No**

8.Can you prepare your own meals? ___ **Yes** ___ **No**

9.Can you manage your medication without help? ___ **Yes** ___ **No**

10.Do you engage in physical activity on a regular basis? ___**Yes** ___ **No**
If yes: How many days per week? _____
Type of activity_____
Duration _____

11.Do you wear a seat belt regulary as both a passenger/driver? ___ **Yes** ___ **No**

12.Do you smoke? ___**Yes** ___ **No**

13.During the past four weeks, was someone available to help you if you needed and wanted help? (For example, if you felt nervous or sad, got sick, needed someone to talk to, or needed help taking care of yourself)
___ **Yes, as much as I wanted** ___ **Yes, somewhat** ___**No, not at all**

TURN OVER -->

14.Have you fallen two or more times in the past year? ___ **Yes** ___ **No**

15.Are you afraid of falling? ___ **Yes** ___ **No**

16.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**

17.Do you drink alcohol? ___ **Yes** ___ **No**
If yes: What do you drink? ___Beer ___ Wine ___Liquor/Mixed Drinks
How many drinks do you have: Each day?____ Each week? ____ Each month? ____

18.Are you having difficulties driving your car? ___ **Yes** ___ **No** ___ **I do not drive**

19.Do you have any difficulties with your hearing? ___ **Yes** ___ **No**

20.Are you having problems using the telephone? ___ **Yes** ___ **No**

21.Do you have any concerns about your sexual health? ___ **Yes** ___ **No**

22.Are you having trouble eating well? ___ **Yes** ___ **No**

23.Do you have any dental or denture problems? ___ **Yes** ___ **No**

24.Are there any hazards in your home that may hurt you? (For example rugs in the hallway, lack of handrails on the stairs, poor lighting, electrical cords in walking areas) ___ **Yes** ___ **No**

25.How confident are you that you can control and manage your health?
___ **Very confident** ___ **Somewhat confident** ___ **Not very confident**

26.How would you rate your overall health?
___ **Execellent** ___ **Very good** ___ **Good** ___ **Fair** ___**Poor**

27.What are your top two health related goals:
a)_____
b)_____

28.Do you have any barriers to prevent you from reaching these goals? ___ **Yes** ___ **No**
If yes, what? _____

29.Do you have a medical power of attorney? ___ **Yes** ___ **No**