alpinemedicalgroup
www.alpinemedicalgroup.com

Name_____**Date**_____
Date of Birth_____**Place of Birth**_____
E-mail Address_____
Preferred Method of Communication_____
May we send general information about our clinic? YES/NO
Name of Primary Care Physician_____

MEDICARE WELLNESS VISIT: HEALTH RISK ASSESSMENT

Current List of Medical Providers, Suppliers:

Physician: _____
Physician: _____
Physician: _____
Physician: _____
Physician: _____

Pharmacy: _____
Pharmacy: _____

Medical Equipment: _____
Home Health: _____
Physical Therapy: _____

Please describe the following regarding your health:

In general, would you say your health is
□ Excellent
□ Very good
□ Good
□ Fair
□ Poor
Comment:_____

How would you describe the condition of your mouth and teeth—including false teeth or dentures?
□ Excellent
□ Very good
□ Good
□ Fair
□ Poor
Comment:_____

How would you describe your hearing?
□ Excellent
□ Very good
□ Good
□ Fair
□ Poor
Comment:_____

Activities of Daily Living (ADLs)

In the past seven days, have you needed help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

□ Yes
Comment: _____

□ No

Instrumental Activities of Daily Living (IADLs)

In the past seven days, have you needed help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

□ Yes
Comment: _____

□ No

Physical Activity

In the past seven days, how many days did you exercise? _____ days

On days when you exercised, for how long did you exercise? _____ minutes/day □ Does not apply

How intense was your typical exercise?

□ Light (like stretching or slow walking)
□ Moderate (like brisk walking)
□ Heavy (like jogging or swimming)
□ Very heavy (like fast running or stair climbing)
□ I am currently not exercising

Sleep

Each night, how many hours of sleep do you usually get? _____ hours

Do you snore or has anyone told you that you snore?

□ Yes
□ No

In the past seven days, how often have you felt sleepy during the daytime?

□ Always
□ Usually
□ Sometimes
□ Rarely
□ Never

Alcohol Use

In the past seven days, on how many days did you drink alcohol? _ days

On days when you drank alcohol, how often did you have four or more alcoholic drinks on one occasion?

□ Never
□ Once during the week
□ 2–3 times during the week
□ More than 3 times during the week

Do you ever drive after drinking, or ride with a driver who has been drinking?

□ Yes
□ No

Seat Belt Use

Do you always fasten your seat belt when you are in a car?
□ Yes
□ No

Nutrition

In the past seven days, how many servings of fruits and vegetables did you typically eat each day?
(1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.)
_____ servings per day

In the past seven days, how many servings of high fiber or whole grain foods did you typically eat each day?
(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)

_____ servings per day

In the past seven days, how many servings of fried or high-fat foods did you typically eat each day?
(Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)

_____ servings per day

In the past seven days, how many sugar-sweetened (not diet) beverages did you typically consume each day?
_____ sugar sweetened beverages consumed per day

Home Safety

In the past six months, have you fallen in your home and/or sustained an injury related to a fall in your home?
□ Yes
Comment: _____
□ No

Do you think that your home would be made safer by any of the following measures?
(Removing tripping hazards in walkways, using non-slip mats in bathtubs and showers, placing grab bars next to the toilet and shower, placing handrails on both sides of a stairway, improving home lighting)
□ Yes
Comment: _____
□ No

End-Of-Life Planning

Do you currently have an advanced directive for health care?
(Example: Durable Power of Attorney for Health Care, Living Will, DNAR Order)
□ Yes
□ No
□ I do not wish to discuss end-of-life planning with my provider at this time