Island Health Care

245 Edgartown-Vineyard Haven Road
P.O. Box 9000
Edgartown, MA 02539
508-939-9358
Fax: 508-939-8644

Dear Island Health Care Patient:

We are glad you have chosen us to be your Medicare health care provider. We value you as a client and we want to help you stay as healthy as possible.

In preparation for your next Medicare wellness visit, please answer a few questions about your health and lifestyle. By answering them, time spent with your provider will focus on your personalized plan. It will only take 10-15 minutes. If you are unable to fill it out, another person who knows you may be able to help. If you would like additional assistance, you may call and schedule a visit with one of our nurses to help you complete the form.

When you have completed the questionnaire, please mail or return the form to:

Island Health Care
PO Box 9000
245 Edgartown-Vineyard Haven Rd
Edgartown, MA 02539
508-939-9358

The information you provide will be kept confidential. It will help us learn more about you and your health and may be reviewed by a care coordinator to help your provider and our team to offer you high quality care.

Thank you for choosing Island Health Care. We are committed to your health.

Sincerely,

Island Health Care Team

Carol Forgione, ACNP
Marcia Denine, WHNP
Susan McSweeney, CNP
Barbara Colocino, CNP
Karen Gauvin, FNP-BC

Medicare Annual Wellness Visit

HEALTH RISK ASSESSMENT

Island Health Care

Today's Date: _____

Patient Name: _____ Date of Birth: _____

GENERAL HEALTH	
1. How is your overall health?	☐ Excellent ☐Good ☐Fair ☐ Poor ☐ I don't know
2. How many different prescriptions are you taking?	☐ 0-3 ☐ 4-6 ☐ 7-10 ☐ 10+ ☐ I don't know
3. Do you take all of your medications as prescribed?	☐ Yes ☐ No ☐ Sometimes ☐ Almost never ☐ I don't take medication
4. Do you know what your medications are for?	☐ Yes ☐ No ☐ Some of them
5. How is the health of your mouth and teeth?	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know
6. Do you have a dentist that you visit regularly?	☐ Yes ☐ No ☐ I don't know
7. How many times in the last 6 months have you been to the emergency room?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
8. How many times in the last 6 months were you admitted to the hospital?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
TOBACCO AND ALCOHOL USE	
9. Do you use any tobacco products?	☐Yes ☐ No
10. Are you interested in quitting tobacco?	☐Yes ☐ No ☐ I don't use tobacco
11. How many times in the past year have you had four or more alcoholic drinks in a day?	☐None ☐ 1-2 ☐ 3-4 ☐ 5+
12. Are you interested in receiving help for any other type of substance use?	☐Yes ☐No ☐ I don't use other substances
NUTRITION	
13. How many servings of fruits and vegetables do you usually eat each day?	☐None ☐1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
14. How many servings of fiber or whole grain foods do you usually eat each day?	☐None ☐ 1-2 ☐ 3-4 ☐5+ ☐ I don't know
PHYSICAL ACTIVITY	
15. How many days a week do you exercise?	☐None ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
16. On the days that you exercised, how long did you exercise?	☐ 0-30 min. ☐ 30 min to 1 hour ☐More than 1 hour ☐ I don't know ☐ I don't exercise
17. How intense is your exercise?	☐Light (stretching, slow walking) ☐ Moderate (brisk walking) ☐ Heavy (jogging, swimming) ☐Very heavy (running fast) ☐ I don't know ☐ I don't exercise

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SLEEP		
18. How many hours of sleep do you usually get?	☐0-3 ☐4-6 ☐7-10 ☐ 10+ ☐ I don't know	
19. Do you snore or has anyone told you that you snore?	☐Yes ☐ No ☐ I don't know	
20. In the past seven days, how often have you felt sleepy during the daytime?	☐Often ☐Sometimes ☐ Almost never ☐ Never ☐ I don't know	
MEMORY		
21. Have you had problems with your short term memory (what did you have for diner last night)?	☐Yes ☐ No	
22. Have you had problems with your long term memory (where were you born)?	☐Yes ☐ No	
FUNCTIONAL STATUS ASSESSMENT		
23. Which of the following can you do on your own without help?	☐ Shop for groceries ☐ Use the telephone ☐ Housework ☐ Handle finances	☐ Drive/ use public transport ☐ Make meals ☐ Take medications ☐ None
Activities of Daily Living		
24. Which of the following can you do on your own?	☐ Bath ☐ Dress ☐ Eat ☐ Walk (transfer in/out of chairs, etc.) ☐ Use the restroom ☐ None	
25. Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?	☐Yes ☐No ☐ I don't know	
Ambulation Status		
26. How long can you walk or move around?	☐ 0-5 min. ☐ 5-15 min. ☐ 15-30 min. ☐ More than 1 hour ☐ I don't know	
27. Which of these assistive devices do you use?	☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Other ☐ None	
28. Do you have trouble with your balance?	☐Yes ☐No	
29. Have you fallen in the last six months?	☐Yes ☐No	
Sensory Ability		
30. Do you have problems with vision?	☐Yes ☐No ☐ I don't know	
31. Do you use eyeglasses or contact lenses?	☐Yes ☐No ☐ I don't know	
32. Do you have problems with hearing?	☐Yes ☐No ☐ I don't know	
33. Do you use hearing aids or other devices to help you hear?	☐Yes ☐No ☐ I don't know	

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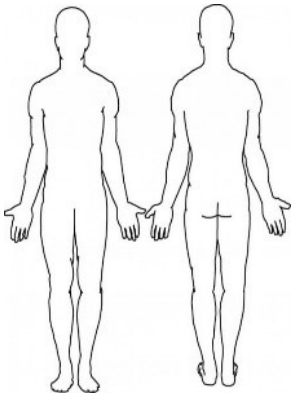
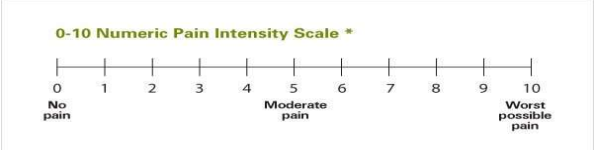
PAIN ASSESSMENT		
34. In the past two weeks, how often have you felt pain? ☐ Almost all of the time ☐ Most times ☐ Sometimes ☐ Almost never ☐ No pain	35. Where is the pain? ☐ No Pain Or Mark all areas indicated on image 	36. How do you treat the pain? ☐ Medication ☐ Rest ☐ Heat or cold ☐ Therapy ☐ Other ☐ No treatment plan ☐ No pain
37. Rate your pain on a scale of 0-10 with 0 being no pain and 10 being the worst pain: Circle the number of the scale		

HOME SAFETY	
38. What is your living situation?	☐ Alone ☐ With my spouse or other family ☐ With a friend or roommate ☐ In a nursing home or assisted living facility/home ☐ I don't have a place to live ☐ Other
39. Does your home have working smoke alarms?	☐ Yes ☐ No ☐ I don't know ☐ NA
40. Do you fasten your seatbelt in vehicles?	☐ Yes ☐ No ☐ I don't ride in vehicles

DEPRESSION	
In the last two weeks, how often have you been bothered by any of the following problems?	
41. Little interest or pleasure in doing things.	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ I don't know
42. Feeling down, depressed, or hopeless.	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ I don't know
43. Trouble falling or staying asleep or sleeping too much.	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ I don't know
44. Feeling tired or having no energy.	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ I don't know
45. Poor appetite or overeating.	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ I don't know
46. Feeling bad about yourself or that you're a failure or have let yourself or your family down.	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ I don't know

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47. Trouble concentrating on things, such as reading the newspaper or watching television.	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ I don't know
48. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you've been moving around a lot more than usual.	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ I don't know
49. Thoughts that you would be better off dead or of hurting yourself.	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ I don't know
50. If you checked off any problems in this section, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not at all ☐ Somewhat ☐ Very difficult ☐ Extremely difficult
SOCIAL/EMOTIONAL SUPPORT	
51. Which of the following applies to you?	☐ I have a supportive family. ☐ I have supportive friends. ☐ I participate in church, clubs, or other group activities. ☐ None
52. How often do you get out and meet with family and friends?	Often ☐ Sometimes ☐ Almost never ☐ None
ADVANCE DIRECTIVES	
53. Do you have a health care power of attorney or a living will?	☐ Yes ☐ No ☐ I don't know ☐ More info please

MEDICATIONS (PRESCRIPTIONS, VITAMNS, OVER THE COUNTER)

Name	Dose	Date started	Condition treating

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SELF AND FAMILY HISTORY					
Mark the columns that apply	**None**	**Self**	**Parent**	**Brother/Sister**	**Child**
Congestive heart failure					
Diabetes					
COPD (chronic lung disease) or Asthma					
Hypertension					
Stroke					
Kidney disease					
Bipolar disorder or Schizophrenia					
Dementia					
Cancer					
Neurological disorders					
Other					

OTHER PHYSICIANS OR HEALTH CARE PROVIDERS		
Specialty	**Physician name**	**Date last seen**
Cardiologist		
Dermatologist		
Ear, nose, and throat		
Endocrinologist		
Eye Doctor		
Gynecologist		
Neurologist		
Physical therapist		
Pulmonologist		
Other		

ALLERGIES- DRUG, FOOD, ENVIROMENTAL	

IMMUNIZATIONS
Have you had: Hepatitis B Vaccine□ Estimated date_____ Annual Flu Vaccine□ Est Date_____ Pneumonia Vaccine□ Est Date_____

OFFICIAL USE ONLY
Reviewed by- Clinician name:
Clinician signature: Date: