Kelly Sharrar, MD
4981 Indian Peak Road
Mariposa, Ca 95338
Phone: (209) 682-5228

Welcome to Medicare/Annual Wellness Visit
Health Risk Assessment: Senior

Name:_____ DOB:___/____/_____ DOV:___/____/_____ HX:____yo	Current Meds: _____ _____ _____ **ALLERGIES**: NKA PEN SULFA ERYTHRO OTHER:

Person completing form: _____

Relationship:_____

Need Interpreter? Yes No

BP____/____ **WT**_____lb **HT**_____ **T**_____ **P**_____ **R**_____
UA_____ **RBS**_____ **FBS**_____ **BMI** _____
VISION: B_____/_____ R_____/_____ L_____/_____

AUDIO	1000	2000	3000	4000
Right				
Left				

Please answer all the questions on this form as best you can. Be sure to talk to your doctor if you have questions about anything on this form. Your answers will be kept private and protected as part of your medical record.

1	Do you eat or drink 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk or tofu?	Yes	No
2	Do you eat 5 or more fruits and/or vegetables every day?	Yes	No
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No
4	Are you easily able to get healthy food?	Yes	No
5	Do you drink soda, juice drinks, sports or energy drinks most days of the week?	Yes	No
6	Do you often eat too much or too little food?	Yes	No
7	Are you concerned about your weight?	Yes	No
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour or more a day?	Yes	No
9	Do you feel safe where you live?	Yes	No
10	Are family members or friends worried about your driving?	Yes	No
11	Have you had any car accidents in the last year?	Yes	No
12	Do you sometimes fall and hurt yourself, or is it hard to get up?	Yes	No
13	Have you been hit, slapped, kicked, or physically hurt by anyone in the last year?	Yes	No
14	Do you always where a seatbelt when driving or riding in a car?	Yes	No
15	Do you keep a gun in your house or place you live?	Yes	No
16	Do you brush and floss your teeth daily?	Yes	No
17	Do you often feel sad, hopeless, angry, or worried?	Yes	No
18	Do you often feel little interest or pleasure in doing things?	Yes	No
19	Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?	Yes	No
20	Do you often have trouble sleeping?	Yes	No
21	Do you or others think you have trouble remembering things?	Yes	No
22	Do you smoke or chew tobacco?	Yes	No
23	Do friends or family members smoke in your home?	Yes	No

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24	In the past year have you had: ☐ Men: 5 or more alcohol drinks in one day? ☐ Women: 4 or more alcohol drinks in one day?	Yes	No
25	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	Yes	No
26	In the past 2 weeks, did you need help from others to take care of things such as, laundry and housekeeping, banking, shopping, food preparation, transportation, or taking your own medications?	Yes	No
27	In the past 2 weeks, did you need help from others getting dressed, bathing or walking?	Yes	No
28	Do you have someone to help you make decisions about your health and medical care?	Yes	No
29	Do you have someone to call when you need help in an emergency?	Yes	No
30	Do you think you or your partner could be pregnant?	Yes	No
31	Do you think your partner could have a sexually transmitted disease (STD)?	Yes	No
32	Have you or your partner(s) had sex without using birth control in the past year?	Yes	No
33	Have you or your partner(s) had sex with other people in the past year?	Yes	No
34	Have you or your partner(s) had sex without a condom in the past year?	Yes	No
35	Have you ever been forced or pressured to have sex?	Yes	No
36	Do you have any other questions or concerns about your health? If yes, please describe:	Yes	No
	Comments:		

☐ I have been offered assistance completing the Healthy Risk Assessment. I refuse to complete the Healthy Risk Assessment. I understand that I will not be eligible to receive a Medicare Initial Preventative Physical Exam (IPPE) or Annual Wellness Visit (AWV).

Patient Signature: Date:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental health	☐	☐	☐	☐
☐ Mental health	☐	☐	☐	☐
☐ Alcohol, tobacco, drug use	☐	☐	☐	☐
☐ Sexual issues	☐	☐	☐	☐
☐ Independent living	☐	☐	☐	☐

Physician Signature: Date:

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Medicare Part B Preventative Services

As a Medicare beneficiary you are eligible to receive the following preventative benefits.

- Abdominal Aortic Aneurysm Screening (male, once in a lifetime)
- Alcohol Misuse Screening and Counseling (annually)
- Annual Wellness Visit (annually)
- Cardiovascular Disease Screening Test (once every five years)
- Cervical and Vaginal Cancer Screening (bi-yearly)
- Colorectal Cancer Screening (varies)
- Counseling to Prevent Tobacco Use (for Asymptomatic Beneficiaries) (8 visits/yr)
- Depression Screening (annually)
- Diabetes Screening (every six months)
- Diabetes Self-Management Training (DSMT)
- Electrocardiogram (EKG/ECG)
- Glaucoma Screening (annually)
- Hepatitis C Virus (HCV) Screening (once in a lifetime)
- Human Immunodeficiency Virus (HIV) Screening (annually)
- Influenza, Pneumococcal, and Hepatitis B Vaccinations and their Administration
- Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD), also known as a CVD risk reduction visit
- IBT for Obesity (as needed)
- Lung Cancer Screening (annually)
- Mammograms (annually)
- Medical Nutrition Therapy (MNT) (3 hrs/first yr, 2hrs/second yr)
- Prostate Cancer Screening (annually)
- Screening for Sexually Transmitted Infections (STIs) Screening and High Intensity Behavioral Counseling (HIBC) to Prevent STIs (annually)
- Bone Density Scan

Patient Signature: Print Name:	Date:
Physician Signature: Kelly Sharrar, MD	Date:

Original copy goes to patient.
Copy for chart.