Patient Name:	
Address:	
Street *Mailing* *City* *State* *Zip code*	
Date of birth:	Race:
Age today:	Ethnicity:
Male Female	

1. Behavioral Risk Factors

Physical Inactivity/Lack of Exercise	**Response**
How many days a week do you usually exercise?	
How much time do you spend exercising during each session?	
How intense is your typical exercise? (check one)	
Light (stretching or slow walking)	
Moderate (brisk walking)	
Heavy (jogging/swimming)	

Smoking/Tobacco use	**Response**
Do you currently smoke cigarettes or use other types of tobacco? (yes or no)	
Are you a former smoker? (check one)	
Yes, quit	
No, never	
Does not apply	
If you quit smoking, how long ago? (check one)	
Less than 6 months	
6-11 months	
1-5 years	
6-10 years	
More than 10 years ago	
Does not apply	
Do you use other tobacco products? (Check all that apply)	
Cigars	
Pipe	
Chewing tobacco/snuff	

Alcohol use	**Response**
In a typical week, how many days do you drink alcohol?	
On days you drink alcohol, how many alcoholic drinks do you consume?	
In a typical week, how often do you have 5 or more alcoholic drinks on one occasion? (check one)	
Never	
Once a week	
2-3 times per week	
More than 3 times per week	

Nutrition	**Response**
On a typical day, how many servings of fruits/and or vegetables do you eat?	
On a typical day, how many servings of high fiber or whole grain foods do you eat?	
On a typical day, how many servings of fried or high-fat foods do you eat?	

Motor Vehicle Safety (yes or no)	**Response**
Do you always fasten your seat belt when in a car?	
Do you ever drive after drinking, or ride with a driver who has been drinking?	

Sun Exposure (yes or no)	**Response**
Do you protect yourself from the sun when outdoors?	

Patient Name:	

Date:

2. Psychosocial Risk Factors

Depression	Response
Over the past 2 weeks, how often have you felt down, depressed, or hopeless? (check one)	
Almost all of the time	
Most of the time	
Some of the time	
Almost never	
Over the past 2 weeks, how often have you felt little interest or pleasure in doing things? (check one)	
Almost all of the time	
Most of the time	
Some of the time	
Almost never	
Have your feelings caused you distress or interfered with your ability to interact socially with friends? (yes or no)	
During the past 6 months, how often have you felt sad or depressed? (check one)	
Almost all of the time	
Most of the time	
Some of the time	
Almost never	

General Life Satisfaction	Response
In general, how satisfied are you with your life? (check one)	
Very satisfied	
Satisfied	
Dissatisfied	
Very dissatisfied	

Sleep	Response
How many hours of sleep do you usually get each night?	

Stress	Response
How often is stress a problem for you? (check one)	
Never/rarely	
Sometimes	
Often	
Always	
How well do you handle the stress in your life? (Check one)	
I'm usually able to cope effectively	
At times I have problems coping	
I often have problems coping	

General Well-Being	Response
In general, would you say your health is (check one)	
Excellent	
Very good	
Good	
Fair	
Poor	

Social/Emotional Support	Response
How often do you get the social and emotional support you need? (check one)	
Always	
Usually	
Sometimes	
Rarely	
Never	

Patient Name:	

Date:

3. Biometric Measures (self-reported)

To be completed by patient unless HRA is prepopulated by laboratory, EHR, PMS, or other medical practice source data

Blood Pressure: If your blood pressure was checked within the past year, what was it when it was last checked? (check one)	
Low or normal (at or below 120/80)	
Borderline high (120/80 to 139/89)	
High (140/90 or higher)	
Don't know/not sure	
Does not apply	

Cholesterol: If your cholesterol was checked within the past year, what was it when it was last checked? (check one)	
Desirable (below 200)	
Borderline high (200-239)	
High (240 or higher)	
Don't know/not sure	
Does not apply	

Blood Glucose: If your glucose was checked within the past year, what was it when it was last checked? (check one)	
Desirable (below 100)	
Borderline high (100-125)	
High (126 or higher)	
Don't know/not sure	
Does not apply	
Have you ever been told by a doctor or health professional that you have diabetes or high blood sugar? (yes or no)	
If you have had your hemoglobin A-1C level checked within the past year, what was it the last time you had it checked? (check one)	
Desirable (6 or lower)	
Borderline high (7)	
High (8 or higher)	
Don't know/not sure	
Does not apply	

Weight/Height	
What is your weight?	
What is your height? (Feet and Inches)	

4. Chemoprophylaxis

Dailey Aspirin Use (yes or no)	**Response**
Have you discussed taking a daily aspirin with your doctor?	

The Medicare Annual Wellness Visit (AWV) is a wellness visit during which the patient's medical history, risk factors, functional ability and routine measurements are captured in order to provide a Personalized Prevention Plan which the patient may choose to follow to maintain good health. The Annual Wellness Visit is NOT the same as a yearly (annual) physical exam.

This form is used in conjunction with the Medicare benefit of an Annual Wellness Visit and is to be updated with each annual visit.