Sample Health Risk Assessment

The health risk assessment (HRA) questions outlined below are provided as examples. They represent one HRA model. Use of this model is not a requirement for the Medicare Annual Wellness Visit HRA, as a variety of HRA instruments will meet the Medicare HRA definition. Physician discretion will guide the implementation and use of HRAs. HRAs are not intended to be prescriptive, and physician judgment will identify appropriate interventions for individual patients. The sample questions reflect available scientific evidence.

Clinics should make plans to accommodate the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs.

Physical Activity

In the past 7 days, how many days did you exercise?
_____ days

On days when you exercised, for how long did you exercise (in minutes)?
_____ minutes per 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

Tobacco Use

In the last 30 days, have you used tobacco?
_____ Yes _____ No
Used a smokeless tobacco product:
_____ Yes _____ No

If Yes to either,
Would you be interested in quitting tobacco use within the next month?

_____ Yes _____ No

Alcohol Use

In the past 7 days, on how many days did you drink alcohol?
_____ days

On days when you drank alcohol, how often did you have ___ (5 or more for men, 4 or more for women and those men and women 65 years old or over) 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

Nutrition

In the past 7 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 7 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 7 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 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?

_____ sugar sweetened beverages consumed per day

Seat Belt Use

Do you always fasten your seat belt when you are in a car?

_____ Yes _____ No

Depression

In the past 2 weeks, how often have you felt down, depressed, or hopeless?

_____ Almost all of the time
_____ Most of the time
_____ Some of the time
_____ Almost never

In the past 2 weeks, how often have you felt little interest or pleasure in doing things?

_____ 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 get along socially with family or friends?

_____ Yes _____ No

Anxiety

In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

_____ Almost all of the time
_____ Most of the time
_____ Some of the time
_____ Almost never

In the past 2 weeks, how often were you not able to stop worrying or control your worrying?

_____ Almost all of the time

_____ Most of the time
_____ Some of the time
_____ Almost never

High Stress

How often is stress a problem for you in handling such things as:
- Your health?
- Your finances?
- Your family or social relationships?
- Your work?

_____ Never or rarely
_____ Sometimes
_____ Often
_____ Always

Emotional Support

How often do you get the social and emotional support you need:
_____ Always
_____ Usually
_____ Sometimes
_____ Rarely
_____ Never

Pain – In the past 7 days, how much pain have you felt?

_____ None
_____ Some
_____ A lot

General Health

In general, would you say your health is
_____ Excellent
_____ Very good
_____ Good
_____ Fair

_____ Poor

How would you describe the condition of your mouth and teeth—including false teeth or dentures?

_____ Excellent
_____ Very good
_____ Good
_____ Fair
_____ Poor

Activities of Daily Living

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

_____ Yes _____ No

Instrumental Activities of Daily Living

In the past 7 days, did you need 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 _____No

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 7 days, how often have you felt sleepy during the daytime?

_____ Always
_____ Usually
_____ Sometimes
_____ Rarely
_____ Never

Biometric Measures—Self-Reported

(To be completed by the patient only when the HRA is not prepopulated using laboratory, electronic medical record (EMR), patient health record (PHR), 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?

_____ 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

Cholesterol

If your cholesterol was checked within the past year, what was your total cholesterol when it was last checked?

_____ Desirable (below 200)
_____ Borderline high (200–239)
_____ High (240 or higher)
_____ Don't know/not sure

Blood Glucose

If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?

_____ Desirable (below 100)
_____ Borderline high (100–125)
_____ High (126 or higher)
_____ Don't know/not sure

If diabetic, and if you have had your hemoglobin A1c level checked in the past year, what was it the last time you had it checked?

_____ Desirable (6 or lower)
_____ Borderline high (7)
_____ High (8 or higher)
_____ Don't know/not sure

Overweight/Obesity

What is your height without shoes? (for example, 5 feet and 6 inches = 5'6")
Feet _____ Inches _____

What is your weight?
Weight in pounds _____

Falls Risk

Have you fallen in the past year?
_____ Yes _____ No

Do you feel unsteady when standing or walking?
_____ Yes _____ No

Do you worry about falling?
_____ Yes _____ No

Home Safety

Have you been given any information to help you with hazards in your house that might hurt you?
_____ Yes _____ No

Optional

Advanced Care Planning – Would you like to discuss advanced care planning (your wishes and preferences for end-of-life care) with your primary care provider?
_____ Yes _____ No

This material, originally prepared by MaineHealth (http://www.mainehealth.org/AWV) was adapted and is provided by HealthInsight, the Medicare Quality Innovation Network – Quality Improvement Organization for Nevada, New Mexico, Oregon and Utah, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. publ #11SOW-CORP-17-17