MEDICARE HEALTH RISK ASSESSMENT (HRA)

Today's Date _____

Patient Name	Date of Birth

Office Use Only: Use patient Health Summary to update Problem List, Allergies, Current Medications, PMH, FH, SH, Diet, Exercise, Tobacco/Alcohol/Caffein Use, and Substance Abuse Use

OTHER PHYSICIANS/PROVIDERS OF CARE (including additional suppliers)

Name & Specialty/Provider Type or Supplier	Type of Care	Date Discontinued

HEARING SCREENING

1. Do you have difficulty hearing a television or radio when others do not?	Yes	No
2. Do you strain/struggle to hear/understand conversations?	Yes	No
3. Do you have trouble hearing in a noisy background?	Yes	No

FUNCTIONAL SCREENING/ACTIVITIES OF DAILY LIVING

1. Do you consider your health to be: ***(please circle one)*** excellent good fair poor		
2. Do you need assistance with transportation?	Yes	No
3. Do you need assistance with shopping for or preparing meals?	Yes	No
4. Do you need assistance with taking your medication?	Yes	No
5. Do you need assistance managing your finances?	Yes	No
6. Do you need assistance in other activities such as grooming, dressing, toileting?	Yes	No
7. Do you need assistance with your housework?	Yes	No

FALL RISK SCREENING

1. Have you fallen two or more times within the past year?	Yes	No
2. Does bending over increase dizziness/imbalance?	Yes	No
3. Does dizziness/imbalance interfere with job/household responsibilities?	Yes	No
4. Are you afraid to leave the house alone due to dizziness/imbalance problems?	Yes	No

HOME SAFETY SCREENING

1. Do you live alone?	Yes	No
2. Do you have throw rugs in your home?	Yes	No
3. Does your home have poor lighting?	Yes	No
4. Do you have a slippery bathtub or shower?	Yes	No
5. Do you have functioning smoke detectors in your home?	Yes	No
6. Do you have grab bars in your bathroom(s)?	Yes	No
7. Do you have handrails on stairs and steps at home?	Yes	No

ADVANCED DIRECTIVE

1. Do you have an Advance Directive in place?	Yes	No
2. Do you want to discuss Advance Directive today?	Yes	No
3. Would you like information about Advance Directive?	Yes	No

I, (print name) _____, consent to discuss end-of-life issues with my healthcare provider.

Patient Signature _____ **Date** _____

Effective 5/11/2018

IRONWOOD Family Practice

Patient Name: _____ **Date:** _____

Two Question Alcohol Screening		
	Yes	**No**
1. Do you consume more than 14 alcoholic drinks per week if male, or more than 7 drinks per week if female?		
2. In the last two years, have you ever consumed more than 4 alcoholic drinks per setting if male or more than 3 alcoholic drinks per sitting if female?		
If you have answered "No" to both questions above, screening is complete. However, if you answered "Yes" to either question above, please continue answering the AUDIT questions below.		

AUDIT

(Alcohol Use Disorders Identification Test)

Because alcohol can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place circle the box that best describes your answer to each question.

Questions	**0**	**1**	**2**	**3**	**4**	**Score**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL	

STANDARD DRINK EQUIVALENTS				**APPROXIMATE NUMBER OF STANDARD DRINKS IN:**
BEER or COOLER	12 oz.		~ 5% alcohol	12 oz = 1 16 oz = 1.3 22 oz = 1.3 40 oz = 1.3
TABLE WINE	5 oz		~ 12% alcohol	750 mL (25 oz.) bottle = 5
80-proof SPIRITS (hard liquor)	1.5 oz.		~ 40% alcohol	a mixed drink = 1 or more * a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39

* Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

IRONWOOD
Family Practice

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

Over the last **2 weeks**, how often have you been bothered by any of the following problems? (*please circle*)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself--or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite--being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns ____ + ____ + ____

TOTAL: ____

10. If you checked off *any problems,* 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 difficult at all	Somewhat difficult	Very difficult	Extremely difficult