



Do not write, stamp,  
punch holes or affix a  
sticker in this area.

Direction of Feed

# Medicare Health Risk Assessment

Please answer every question

To reproduce, follow the  
printing instructions.  
Fold only on the dotted lines.

## FUNCTIONAL ABILITY AND LEVEL OF SAFETY

Do you need help from others to perform everyday activities such as:

eating	<input type="radio"/> yes	<input type="radio"/> no
getting dressed	<input type="radio"/> yes	<input type="radio"/> no
grooming	<input type="radio"/> yes	<input type="radio"/> no
bathing	<input type="radio"/> yes	<input type="radio"/> no
walking	<input type="radio"/> yes	<input type="radio"/> no
using the toilet	<input type="radio"/> yes	<input type="radio"/> no

Do you need help from others to take care of such things as:

laundry	<input type="radio"/> yes	<input type="radio"/> no
housekeeping	<input type="radio"/> yes	<input type="radio"/> no

please fold on dotted line

shopping	<input type="radio"/> yes	<input type="radio"/> no
banking	<input type="radio"/> yes	<input type="radio"/> no
transportation	<input type="radio"/> yes	<input type="radio"/> no
taking medicine	<input type="radio"/> yes	<input type="radio"/> no
preparing meals	<input type="radio"/> yes	<input type="radio"/> no
using the telephone	<input type="radio"/> yes	<input type="radio"/> no

## HOME SAFETY

Do you live alone?  yes  no

Does your home have any of the following?

throw rugs	<input type="radio"/> yes	<input type="radio"/> no
poor lighting	<input type="radio"/> yes	<input type="radio"/> no
slippery bathtub or shower	<input type="radio"/> yes	<input type="radio"/> no

Does your home LACK any of the following?

grab bars in bathrooms	<input type="radio"/> yes	<input type="radio"/> no
handrails on stairs or steps	<input type="radio"/> yes	<input type="radio"/> no
functioning smoke alarms	<input type="radio"/> yes	<input type="radio"/> no

please fold on dotted line

## FALL RISK

Have you had 2 or more falls in the past year?  yes  no

Any fall with injury in the past year?  yes  no

Are you worried about falling or feel unsteady when standing or walking?  yes  no

## HEARING LOSS SCREENING

Do you have trouble hearing the television or radio when others do not?  yes  no

Do you have to strain or struggle to hear/understand conversations?  yes  no

## ADVANCED CARE PLANNING

Do you have an Advance Directive (Living Will)?  yes  no