

Patient Name: _____ Date of Birth: _____ Date: _____

MEDICARE AWW HEALTH RISK ASSESSMENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Today's Date: _____

1. Have you had 2 or more falls in the last year?	☐ Yes ☐ No ☐ Unknown
2. Have you had a fall with injury in the last year?	☐ Yes ☐ No ☐ Unknown
3. Do you have difficulty with walking or balance?	☐ Yes ☐ No ☐ Unknown
4. Are you deaf or do you have serious difficulty hearing?	☐ Yes ☐ No
5. Have you noticed any changes in your memory lately?	☐ Yes ☐ No
6. In the past 2 weeks, how often have you felt nervous, anxious, or on edge?	☐ Almost never ☐ Some of the time ☐ Most of the time ☐ Almost all of the time
7. In the past 2 weeks, how often were you not able to stop worrying or control your worrying?	☐ Almost never ☐ Some of the time ☐ Most of the time ☐ Almost all of the time
8. In general, would you say your health is?	☐ Excellent ☐ Good ☐ Fair ☐ Poor
9. How confident are you that you can manage most of your health problems?	☐ Very confident ☐ Somewhat confident ☐ Not very confident ☐ I do not have any health problems
10. During the past 12 months, have you helped out a relative or friend with health and/or life tasks, even just a little bit?	☐ Yes ☐ No
11. Do you feel stressed by these caregiving/helping responsibilities?	☐ Yes ☐ No
12. 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
13. In the past 7 days, did you need help from others to take care of things such as laundry, housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your own medicine?	☐ Yes ☐ No
14. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	☐ Never ☐ Rarely ☐ Sometimes ☐ Often

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MEDICARE AWP SOCIAL DETERMINANTS OF HEALTH QUESTIONNAIRE

1. On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?
☐ 0 days ☐ 3 days ☐ 6 days
☐ 1 day ☐ 4 days ☐ 7 days
☐ 2 days ☐ 5 days ☐ Decline
2. On average, how many minutes do you engage in exercise at this level? Check the number of minutes.
☐ 0 ☐ 50 ☐ 90 ☐ 130
☐ 10 ☐ 60 ☐ 100 ☐ 140
☐ 20 ☐ 70 ☐ 110 ☐ 150+
☐ 30 ☐ 80 ☐ 120 ☐ Decline
☐ 40
3. How hard is it for you to pay for the very basics, like food, housing, medical care, and heating?
☐ Not hard at all ☐ Somewhat hard ☐ Very hard
☐ Not very hard ☐ Hard ☐ Decline
4. In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time? ☐ Yes ☐ No ☐ Decline
5. In the last 12 months, how many places have you lived?
6. In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)? ☐ Yes ☐ No ☐ Decline
7. In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications? ☐ Yes ☐ No ☐ Decline
8. Within the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living? ☐ Yes ☐ No ☐ Decline
9. In the past 12 months, you worried that your food would run out before you got the money to buy more.
☐ Never true ☐ Often true ☐ Decline
☐ Sometimes true
10. Within the past 12 months, the food you bought just didn't last and you didn't have the money to get more.
☐ Never true ☐ Often true ☐ Decline
☐ Sometimes true
11. Do you feel stressed – tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time – these days?
☐ Not at all ☐ To some extent ☐ Very much
☐ Only a little ☐ Rather much ☐ Decline
12. In a typical week, how many times do you talk on the phone with family, friends, or neighbors?
☐ Never ☐ Three times a week ☐ Decline
☐ Once a week ☐ More than three times a week
☐ Twice a week
13. How often do you get together with friends or relatives?
☐ Never ☐ Three times a week ☐ Decline
☐ Once a week ☐ More than three times a week
☐ Twice a week

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MEDICARE AWW SOCIAL DETERMINANTS OF HEALTH QUESTIONNAIRE

14. How often do you attend church or religious services?
☐ Never ☐ 1 to 4 times per year ☐ More than 4 times per year ☐ Decline
15. How often do you attend meetings of the clubs or organizations you belong to?
☐ Never ☐ 1 to 4 times per year ☐ More than 4 times per year ☐ Decline
16. Are you married, widowed, divorced, separated, never married, or living with a partner?
☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never married ☐ Living with a partner ☐ Decline
17. Within the last year, have you been afraid of your partner or ex-partner? ☐ Yes ☐ No ☐ Decline
18. With the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? ☐ Yes ☐ No ☐ Decline
19. Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? ☐ Yes ☐ No ☐ Decline
20. Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? ☐ Yes ☐ No ☐ Decline
21. 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 ☐ Decline
22. 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 ☐ Decline
23. How often do you have six or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐ Decline
24. We have care team members with special knowledge of assistance programs and community resources. Help is free and confidential. What kind of help would you like? (select all that apply)
☐ I would like help ☐ I would like information about help ☐ I already have help ☐ I do not need help

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In the past two weeks:

Trouble concentrating on things, such as reading the newspaper or watching television?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Thoughts that you would be better off dead, or of hurting yourself?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Stress, Social Support, and Pain

How often is stress a problem for you in handling your health, finances, family or social relationships?

☐ Hardly Ever ☐ Sometimes ☐ Often

In the past 7 days, how often have you felt angry?

☐ Hardly Ever ☐ Sometimes ☐ Often

How often do you feel you lack companionship?

☐ Hardly Ever ☐ Sometimes ☐ Often

How often do you feel left out?

☐ Hardly Ever ☐ Sometimes ☐ Often

How often do you feel isolated from others?

☐ Hardly Ever ☐ Sometimes ☐ Often

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

☐ Hardly Ever ☐ Sometimes ☐ Often

Additional Health Questions

Do you have concerns about your memory?

☐ No ☐ Yes

Have family or friends been concerned about your memory?

☐ No ☐ Yes

Do you have concerns about sex?

☐ No ☐ Yes

Do you have problems with your teeth or gums?

☐ No ☐ Yes

Do you have dentures?

☐ No ☐ Yes

Do you see a dentist?

☐ No ☐ Yes

Does anyone have concerns about your hearing?

☐ No ☐ Yes

Vitamins - check the ones you take

☐ None ☐ Vitamin D ☐ Calcium ☐ Multi-vitamin ☐ Other: _____

Diet

- How many fruits and vegetables do you eat on most days? _____

- How many fried foods do you eat on most days? _____

- How many 8 oz. glasses of fruit juice or sweetened beverages do you drink on most days? _____

Within the past 12 months, I/we have worried about whether our food would run out before we had enough money to buy more:

☐ Often ☐ Sometimes ☐ Never

Within the past 12 months, the food I/we bought just did not last and we did not have money to get more:

☐ Often ☐ Sometimes ☐ Never

Functioning at Home

Dress yourself	☐ Able to	☐ Not able to	☐ Find it difficult to
Feed yourself	☐ Able to	☐ Not able to	☐ Find it difficult to
Toilet yourself	☐ Able to	☐ Not able to	☐ Find it difficult to
Groom yourself	☐ Able to	☐ Not able to	☐ Find it difficult to
Bathe yourself	☐ Able to	☐ Not able to	☐ Find it difficult to
Handle your finances	☐ Able to	☐ Not able to	☐ Find it difficult to
Obtain and take your medicines	☐ Able to	☐ Not able to	☐ Find it difficult to
Get in and out of a car	☐ Able to	☐ Not able to	☐ Find it difficult to
Walk 1-4 blocks	☐ Able to	☐ Not able to	☐ Find it difficult to
Walk 5-9 blocks	☐ Able to	☐ Not able to	☐ Find it difficult to
Walk 10 or more blocks	☐ Able to	☐ Not able to	☐ Find it difficult to
Go down steps	☐ Able to	☐ Not able to	☐ Find it difficult to
Go up steps	☐ Able to	☐ Not able to	☐ Find it difficult to
Kneel	☐ Able to	☐ Not able to	☐ Find it difficult to
Put on socks and shoes	☐ Able to	☐ Not able to	☐ Find it difficult to
Shop for yourself	☐ Able to	☐ Not able to	☐ Find it difficult to
Prepare your own food	☐ Able to	☐ Not able to	☐ Find it difficult to
Do your housekeeping	☐ Able to	☐ Not able to	☐ Find it difficult to
Do your laundry	☐ Able to	☐ Not able to	☐ Find it difficult to
Use a telephone	☐ Able to	☐ Not able to	☐ Find it difficult to
What transportation do you use? _____ <i>(for example: taxi, drive your car, family drives you, friend drives you, etc.)</i>			

Home Safety

Do you have smoke detectors in your home?	☐ No	☐ Yes
Do you have firearms in your home?	☐ No	☐ Yes
Do you use a seat belt when in a vehicle?	☐ No	☐ Yes

Falls

Did you fall in the last year?	☐ No	☐ Yes
If so, did the fall(s) result in injury?	☐ No	☐ Yes
Do you use a cane or walker?	☐ No	☐ Yes
Do you have trouble with balance?	☐ No	☐ Yes

How would you describe your physical activity level?

☐ **None** - You are not physically active and spend most of your time sitting or resting.

☐ **Low** - You do light physical activity (able to have a normal conversation while moving).

☐ **Medium** - You do some moderate physical activity (breathing harder, more difficult to talk while moving) per week.

☐ **High** - You do 150+ minutes/week of moderate activity, or 75+ minutes/week of vigorous activity.

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Alcohol

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
How many standard drinks containing alcohol do you have in a typical day when you drink?
☐ None ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more
How often do you have 6 or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Tobacco and Vaping

Do you use tobacco?
☐ No ☐ Yes ☐ If yes, what kind? _____ ☐ Number per day? _____ ☐ Former user - age when quit _____
Do you vape or use electronic cigarettes?
☐ No ☐ Yes ☐ If yes, what kind? _____ ☐ Number per day? _____ ☐ Former user - age when quit _____

Other Medications

Do you take opioids (narcotics)?
☐ No ☐ Yes
Do you take drugs you obtained elsewhere?
☐ No ☐ Yes

Medical History Update

Illnesses since last visit
☐ No ☐ Yes ☐ Details if yes: _____
Injuries since last visit
☐ No ☐ Yes ☐ Details if yes: _____
Hospital stays since last visit
☐ No ☐ Yes ☐ Details if yes: _____
Specialists since last visit
☐ No ☐ Yes ☐ Details if yes: _____
Operations since last visit
☐ No ☐ Yes ☐ Details if yes: _____

Family History Update

Write new health problems since your last visit for your:
Parents: _____
Siblings: _____ ☐ No siblings
Children: _____ ☐ No children

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Patient Health Questionnaire (PHQ-9)

Today's Date: _____ Patient Name: _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
Total each column				

A. 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

Comments:

For Office Use Only:

Total score: _____

Routine Screening for Mild Cognitive Impairment

Recommendations from the State Plan for Alzheimer's Disease and Related Dementias in Maine, 2012.

➤ ***“Have you noticed any changes in your (or in your parent's) memory recently?”*** **No Yes**

➤ ***“Are you (or is your parent) less well organized than in the past?”*** **No Yes**

Mild Cognitive Impairment (MCI) is the clinical term delineating the transition from normal cognition to dementia, which designates a level of severity that causes significant impairment in social or occupational functioning and represents a significant decline from a previous level of functioning. It is a pathological state that represents the earliest signs of a neurodegenerative disorder.

Most standardized office assessments of cognition are designed to diagnose dementia and not sensitive enough to confidently detect MCI. However, the symptoms of MCI, such as trouble with memory, are quite apparent to patients and their family members. Thus a simple screening question such as *“Have you noticed any changes in your (or in your parent's) memory recently?”* actually offers value in identifying individuals at risk.

Furthermore, executive cognition can decline while memory is spared. Thus a second screening question such as *“Are you (or is your parent) less well organized than in the past?”* can help identify possible incipient executive cognitive decline.

We propose that all Mainers 65 and older are asked these questions once yearly. Individuals answering in the affirmative should be followed more closely for progression of memory or any other mild cognitive symptom.