Patient Name: ____ **Date of Birth:** _______________
Date of visit: ____________________ **Medical Record Number:** ___________________________

MEDICARE HRA

Current Living Arrangement

Alone
Spouse/Significant Other
Family Member
Assisted Living facility
Retirement community
Other

During the past 4 weeks, how much pain in your body have you had on a scale of -10?

No pain (0)
Very mild pain (1-2)
Mild pain (3-4)
Moderate pain (5-6)
Moderately severe pain (7-8)
Severe pain (9-10)

During the past 4 weeks, was someone available to help you if you needed and wanted help?

No assistance needed
Yes, as much as I wanted
Yes, quite a bit
Yes, some
Yes, a little
No, not at all

During the past 4 weeks, what was the hardest level of physical activity you could do for at least 2 minutes?

Very heavy
Heavy
Moderate
Light
Very light

Each night, how many hours of sleep do you usually get?
# of hours: __________

Do you snore or has anyone told you that you snore?

No
Yes

Do you always fasten your seatbelt when you are in a car?

Yes
No

Do you drive after drinking alcohol or ride with a driver who has been drinking?

No
Yes

How often during the past 4 weeks have you been bothered by falling or dizziness when standing up?

Never
Seldom
Sometimes
Often
Always

How often during the past 4 weeks have you been bothered by sexual problems?

Never
Seldom
Sometimes
Often
Always

Do any of the following describe you? Multiple sexual partners and/or intercourse with partner of the same sex

No
Yes

How often during the past four weeks have you been bothered by teeth or denture problems?

Never
Seldom
Sometimes
Often
Always

How often during the past four weeks have you been bothered by tiredness or fatigue?

Never
Seldom
Sometimes
Often
Always

During the past four weeks, how would you rate your health in general?

Excellent
Very good
Good
Fair
Poor

Patient Name:____________________________

DOB:_____________________

(or use patient label)

Name / MR # / Label

What is your race? (Check all that apply)

American Indian or Alaskan Native
Asian
Black or African-American
Hispanic or Latino origin
White
Other

FUNCTIONAL AND COGNITIVE ASSESSMENT

Is this person deaf or does he/she have serious difficulty hearing?

No
Yes

Is this person blind or does he/she have serious difficulty seeing even when wearing glasses?

No
Yes

Do you/patient have serious difficulty concentrating, remembering, or making decisions?

No
Yes

Have you had any concerns about changes in your memory or concentration?

No
Yes

ADL ASSESSMENT

Please select any of the following that you have serious difficulty managing on your own:

None apply
Walking
Climbing stairs
Dressing
Bathing
Going to the toilet
Feeding yourself
Eating

Please select any of the following that you have serious difficulty managing on your own:

None apply
Interacting with others
Driving
Shopping
Managing your money
Preparing meals
Managing medication
Using the telephone
Doing housework

Patient Name:___________________________
DOB:____________________
(or use patient label)
Name / MR # / Label

PHYSICAL ACTIVITY

On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?

- 0 days
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days
- Patient refused

On average, how many minutes do you engage in exercise at this level?

- 0 min
- 10 min
- 20 min
- 30 min
- 40 min
- 50 min
- 60 min
- 70 min
- 80 min
- 90 min
- 100 min
- 110 min
- 120 min
- 130 min
- 140 min
- 150+ min
- Patient refused

FINANCIAL RESOURCE STRAIN

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

- Very hard
- Hard
- Somewhat hard
- Not very hard
- Not hard at all
- Patient refused

HOUSING SCREENER

In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?

- Yes
- No
- Patient refused

In the last 12 months, how many places have you lived? Enter number here: __________

In the last 12 months, was there a time when you did not have a steady place to sleep of slept in a shelter (including now)?

Yes
No
Patient refused

TRANSPORTATION NEEDS

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

Yes
No
Patient refused

In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?

Yes
No
Patient refused

FOOD INSECURITY

Within the last 12 months, you worried that your food would run out before you got the money to buy more.

Never true
Sometime true
Often true
Patient refused

Within the last 12 months, the food you bought just didn't last and you didn't have money to get more.

Never true
Sometime true
Often true
Patient refused

STRESS

Do you feel stress – tense, restless, nervous, anxious, or unable to sleep at night because your mind is troubled all the time – these days?

Not at all
Only a little
To some extent
Rather much
Very much
Patient refused

SOCIAL CONNECTIONS

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?

Never
Once a week
Twice a week
Three times a week
More than three times a week
Patient refused

How often do you get together with friends or relatives?

Never
Once a week
Twice a week
Three times a week
More than three times a week
Patient refused

How often do you attend church or religious service?

Never
1 to 4 times per year
More than 4 times per year
Patient refused

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?

Yes
No
Patient refused

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
Patient refused

Are you married, widowed, divorced, separated, never married, or living with a partner?

Married
Widowed
Divorced
Separated
Never married
Living with a partner
Patient refused

Patient Name:____________________________
DOB:_____________________
(or use patient label)
Name / MR # / Label

ALCOHOL USE

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
Patient refused

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
Patient refused

How often do you have six or more drinks on one occasion?

Never
Less than monthly
Monthly
Weekly
Daily or almost daily
Patient refused

PERSONAL DATA SHEET

Do you depend on people living with you for personal care?

No
Yes

Are there any cultural or religious beliefs that your healthcare provider should be aware of that would be helpful in your health care?

Yes
No

If you answered yes above, please list those here:

____

____

____

ADVANCE CARE DIRECTIVES

Do you have a living will?

No
Yes

Do you have a Healthcare Power of Attorney?

No
Yes

If you answered yes above, who is your Healthcare Power of Attorney?
Write name here: ____________________________________

FALL RISK SCREENING

Are you able to walk?

Yes
No

*If you answered **No**, then you **may skip** the remainder of the questions below.*

In the last year, have you had 2 or more falls, trips or stumbles where you landed on the ground?

No
Yes

In the last year, have you had 1 or more falls, trips or stumbles where you hurt yourself?

No
Yes

*If you answered **No**, then you **may skip** the remainder of the questions below.*

Do you feel you could benefit from installing grab bars on your tub and/or shower?

No
Yes

Do you use scatter rugs throughout your home?

No
Yes

Get dizzy or lightheaded when you change positions?

No
Yes

Problems walking for any reason?

No
Yes

Patient Name:___________________________
DOB:____________________
(or use patient label)
Name / MR # / Label

Vision Problems?

No
Yes

Do you use anything or anyone to help you walk?

No
Yes

CARE TEAM

Please list all of the physicians that you are currently seeing (please include your eye care provider and any specialists):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

DEPRESSION SCREENING

Over the **past two weeks**, have you been bothered by any of the following problems? Please **circle** the answer in the column that best describes you.

	Not at all	Several days	More than half 7 days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
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?	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in any way	0	1	2	3
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

If limited English proficient or hearing impaired, offer interpreter at no additional cost:
☐ Interpreter Accepted ______________________________ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

Patient Name:______________________

DOB:__________________

(or use patient label)

Name / MR # / Label