Appendix:
Sample Health Risk Assessment (HRA) Overview

Source: *A Framework for Patient-Centered Health Risk Assessments - Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries (cdc.gov)*

The 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 (i.e., could utilize the PHQ-9 questionnaire to assess for Depression and Anxiety.) 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.

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? Smoked: ☐ Yes ☐ No 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 the following number of 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	☐ Never or rarely	☐ Never or rarely	☐ Never or rarely
☐ Sometimes	☐ Sometimes	☐ Sometimes	☐ Sometimes
☐ Often	☐ Often	☐ Often	☐ Often
☐ Always	☐ Always	☐ Always	☐ Always

Social/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

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