Main Line HealthCare
Physician Network

Health Risk Assessment (HRA)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Patient Name:	**DOB:**	**Today's Date:**

Please complete this health assessment prior to seeing your healthcare team. Your answers will help you receive the best care possible.

1. During the past 4 weeks, how much bodily pain have you generally had?
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain

2. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.
   - ☐ Yes, as much as I wanted
   - ☐ Yes, quite a bit
   - ☐ Yes, some
   - ☐ Yes, a little
   - ☐ No, not at all

3. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
   - ☐ Very heavy
   - ☐ Heavy
   - ☐ Moderate
   - ☐ Light
   - ☐ Very light

4. During the past 4 weeks, how would you rate your health in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

	Yes	No
5. Can you get places out of walking distance without help? For example, can you travel by bus, taxi, or drive your own car?	☐	☐
6. Can you shop for groceries or clothes without help?	☐	☐
7. Can you prepare your own meals?	☐	☐
8. Can you do your own housework without help?	☐	☐
9. Can you handle your own money without help?	☐	☐
10. Do you need help eating, bathing, dressing, or getting around your home?	☐	☐

11. How have things been going for you during the past 4 weeks?
   - ☐ Very well- could hardly be better
   - ☐ Pretty good
   - ☐ Good and bad parts about equal
   - ☐ Pretty bad
   - ☐ Very bad- could hardly be worse

12. Are you having difficulties driving your car?
   - ☐ Yes, often
   - ☐ Sometimes
   - ☐ No
   - ☐ Not applicable, I do not use a car

13. Do you always fasten your seatbelt when you are in a car?
   - ☐ Yes, usually
   - ☐ Yes, sometimes
   - ☐ No

14. How often during the past 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up					
Sexual Problems					
Trouble eating well					
Teeth or dentures					
Problems using the telephone					
Tired or fatigued					

15. Have you fallen 2 or more times in the past year?
- ☐ Yes
- ☐ No

16. Are you afraid of falling?
- ☐ Yes
- ☐ No

17. Are you a smoker?
- ☐ No
- ☐ Yes, and I might quit
- ☐ Yes, but I'm not ready to quit

18. During the past 4 weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?
- ☐ 10 or more per week
- ☐ 6-9 per week
- ☐ 2-5 per week
- ☐ 1 drink or less per week
- ☐ No alcohol at all

19. Do you exercise for about 20 minutes 3 or more days per week?
- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ No, I usually do not exercise this much

20. Have you been given any information to help you with the following?
- Hazards in your house that might hurt you
  - ☐ Yes
  - ☐ No
- Keeping track of your medications
  - ☐ Yes
  - ☐ No

21. How often do you have trouble taking medicines the way you have been told to take them?
- ☐ I do not have to take medicine
- ☐ I always take them as prescribed
- ☐ Sometimes I take them as prescribed
- ☐ I seldom take them as prescribed

22. How confident are you that you can control and manage most of your health problems?
- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ I do not have any health problems

23. Do you have difficulty with your hearing?
- ☐ Yes
- ☐ No

How old are you?
- ☐ 65-69 years
- ☐ 70-79 years
- ☐ 80 or older

Are you male or female?
- ☐ Male
- ☐ Female

What is your race? (check one or more than one)
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Hispanic or Latino origin or decent
- ☐ Other