Health Risk Assessment

Name	DOB	Date

List the names of all your doctors (use additional sheet if necessary)		
Name	**Specialty**	**Reason**

List your current medications. Be sure to include prescriptions, over the counter medications, vitamins, supplements, ointments, creams, eye drops and patches (use additional sheet if necessary)	
Name	**Dosage**

List of allergies (use additional sheet if necessary)	
Allergy	**Reaction**

Hospitalizations and ER visits in the past year (use additional sheet if necessary)	
Date	**Reason**

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Personal Medical History (check all that apply)					
Condition	**Yes**	**Condition**	**Yes**	**Condition**	**Yes**
Abnormal Bleeding	☐	Asthma or Emphysema	☐	Blood Clots	☐
Cancer	☐	*Indicate type*			
Congestive Heart Failure	☐	COPD (Chronic Obstructive Pulmonary Disease)	☐	Depression or Anxiety	☐
Diabetes	☐	Heart Disease	☐	Hepatitis	☐
High Blood Pressure	☐	High Cholesterol	☐	HIV or AIDS	☐
Joint Problems	☐	Kidney Disease	☐	Organ Transplant	☐
Pacemaker	☐	Stroke	☐	Thyroid Disorder	☐
Other (please specify)	☐		☐		☐
	☐		☐		☐
	☐		☐		☐

Surgical History (use additional sheet if necessary)	
Date	**Surgery / Procedure**

Family History (check all that apply and indicate affected family member: mother, father, brother, sister, son, daughter)					
Condition	**Yes**	**Relation**	**Condition**	**Yes**	**Relation**
Abnormal Bleeding or Clotting	☐		Breathing Disorder	☐	
Cancer	☐		Congestive Heart Failure	☐	
Depression or Anxiety	☐		Diabetes	☐	
Heart Disease	☐		High Blood Pressure	☐	
High Cholesterol	☐		Joint Problems	☐	
Stroke	☐		Thyroid Disorder	☐	
Other (please specify)	☐			☐	
	☐			☐	
	☐			☐	

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How would you rate the following?

Overall Health	☐ *Excellent*	☐ *Very Good*	☐ *Good*	☐ *Fair*	☐ *Poor*
Physical Health	☐ *Excellent*	☐ *Very Good*	☐ *Good*	☐ *Fair*	☐ *Poor*
Emotional Health	☐ *Excellent*	☐ *Very Good*	☐ *Good*	☐ *Fair*	☐ *Poor*
Eyesight (compared to last year)	☐ *Same*	☐ *Slightly Worse*	☐ *Much Worse*		
Hearing (compared to last year)	☐ *Same*	☐ *Slightly Worse*	☐ *Much Worse*		

How much pain have you had over the past 4 weeks?

☐ *None* ☐ *Very Mild* ☐ *Mild* ☐ *Moderate* ☐ *Severe*

Please answer the following questions

During the past two weeks, have you:				
Felt down, depressed or hopeless?	☐ *Not at all*	☐ *Some days*	☐ *Most Days*	☐ *Every Day*
Had little interest in doing things?	☐ *Not at all*	☐ *Some days*	☐ *Most Days*	☐ *Every Day*
Have you fallen within the past year?	☐ *No*	☐ *Yes*	*How many times?* _____	
Do you use a cane or walker?	☐ *No*	☐ *Yes*		
Have you broken a bone?	☐ *No*	☐ *Yes*		
Have you had a bone mineral density test?	☐ *No*	☐ *Yes*		

Nutrition and Exercise Habits

How many servings of fruits and vegetables do you typically eat each day? _____*servings/day*

How many servings of high fiber foods or whole grains do you typically eat each day? _____*servings/day*

How many servings of fried or high fat foods do you typically eat each day? _____*servings/day*

How many sugar sweetened beverages do you typically drink each day? _____*servings/day*

How often do you engage in physical activity (walking, swimming, cycling, etc.) for at least 20 to 30 minutes?

_____*times/week*

Immunizations

Have you had a flu vaccination within the past year?	☐ *Yes*	☐ *No*
Have you had a pneumonia vaccination?	☐ *Yes*	☐ *No*
Have you had a shingles vaccination?	☐ *Yes*	☐ *No*

Home Safety and Activities of Daily Living

Do you have trouble with the stairs inside or outside your home?	☐ *Yes*	☐ *No*
Do you have hazards inside the home such as a lack of grip bars in the bathtub, loose rugs or poor lighting?	☐ *Yes*	☐ *No*
Does your home have working smoke alarms?	☐ *Yes*	☐ *No*
Does your home have a carbon monoxide monitor?	☐ *Yes*	☐ *No*
Can you get out of bed by yourself?	☐ *Yes*	☐ *No*

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Can you dress yourself?	☐ *Yes*	☐ *No*
Can you make your own meals?	☐ *Yes*	☐ *No*
Can you do your own shopping?	☐ *Yes*	☐ *No*
Can you bathe yourself?	☐ *Yes*	☐ *No*
Can you do your laundry/housekeeping?	☐ *Yes*	☐ *No*
Can you manage your money, pay your bills and track your expenses?	☐ *Yes*	☐ *No*
Do you leave your home to run errands, go to work, meetings, or religious or social functions (not counting doctor visits)?	☐ *Yes*	☐ *No*

Social Habits

Do you smoke or use other tobacco products?	☐ *Yes*	☐ *No*
Have you smoked or used other tobacco products in the past?	☐ *Yes*	☐ *No*
Do you drink alcohol?	☐ *Yes*	☐ *No*
Do you drive?	☐ *Yes*	☐ *No*
Do you use seat belts?	☐ *Yes*	☐ *No*
Do you understand why you're prescribed your medications?	☐ *Yes*	☐ *No*
Are you taking your medications as directed by your doctor?	☐ *Yes*	☐ *No*
Do you experience any side effects from your medications?	☐ *Yes*	☐ *No*

Please describe: _____

Are you concerned about the cost of your medications?	☐ *Yes*	☐ *No*
Do you ever forget to take your medications?	☐ *Yes*	☐ *No*

Advance Directives

Have you decided who would speak for you and make health care treatment choices for you if you became ill and could not make them for yourself?	☐ *Yes*	☐ *No*
If you answered "yes" to the question above, have you spoken to that person about your choices?	☐ *Yes*	☐ *No*
Have you completed a written advance directive (living will and/or health care power of attorney)?	☐ *Yes*	☐ *No*

Office Use Only Provider: _____ Date: _____

Place health risk assessment in the patient's chart.