

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date: \_\_\_\_\_

### Health Risk Assessment Form

**\*\*\*Please complete all sections before seeing your provider\*\*\***

In general, my overall health is:  excellent  very good  good  fair  poor

**List any hospitalizations, major illness, or visits to the emergency room since last year or last visit**

Date	Reason	Location

#### Medical History

Personal and Family Medical History <input type="checkbox"/> No changes since last year/visit						
	Me	Father	Mother	Siblings	Children	Specify Disease
Coronary Disease						
High Blood Pressure						
High Cholesterol						
Cerebral Vascular Disease / Stroke						
Renal Disease						
Cancer						
Diabetes						
Aortic Aneurysm						
Amputation	Location: _____					
Past Surgeries	Date	Past Surgeries	Date			

#### Names of All Providers / Specialists You See:

Doctor's Name	Specialty Type and Reason You See Them

#### List of Medical Equipment/Service Providers

Supply	Who provides this service for you?
Oxygen/CPAP	

Diabetic Supplies	
Home Health	
Other	

**Changes in medications or allergies since last year or last visit**  No changes since last year/visit

*New patients may document additional medications on the back of this form*

Medication	Dose	Reason for Taking	
Allergies	Reaction	Allergies	Reaction

Medications: What pharmacy fills your prescriptions? \_\_\_\_\_

Are you having trouble taking your medications as prescribed? Yes  No

Are you interested in having your prescriptions sent to your home? Yes  No

**Accident Prevention:**

Do you wear seatbelts in the car?  Yes  No

Do you have smoke detectors at home?  Yes  No

Do you have carbon monoxide detectors?  Yes  No

Do you have firearm(s) at home?  Yes  No If yes, locked up?  Yes  No

**Activities of Daily Living**

**Do you require assistance with any of the following activities?**

Using the telephone  Yes  No Eating  Yes  No

Shopping  Yes  No Getting from bed to chair  Yes  No

Meal preparation  Yes  No Dressing  Yes  No

Housekeeping  Yes  No Bathing  Yes  No

Laundry  Yes  No Walking  Yes  No

Driving/taking taxi or bus  Yes  No Getting on/off toilet  Yes  No

Taking medications  Yes  No Urinary/Bowel Incontinence  Yes  No

Handling finances  Yes  No

**Would you like to speak to your provider about bladder control or trouble with urinary leakage?**  Yes  No

I have someone available to help if needed (for a sick day)  Yes, any time  Yes, sometimes  Not really

Personal concern about your memory - or family mentions concern  Yes  No

Diet:  balanced  vegetarian  diabetic  low salt  low fat  low carb  other: \_\_\_\_\_

Do you exercise every day?  No  Yes If not daily, how often? \_\_\_\_\_

Have you had any falls in the past year?  No  Yes If yes, any injuries: \_\_\_\_\_

I use a:  cane  prosthetic  walker  wheelchair/scooter  other: \_\_\_\_\_

In the last two weeks check (✓) how often you have been bothered by the following:	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself—or that you are 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				
Add columns for total score:				

If you checked *any* problems, 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

Do you drink alcohol?  Yes  No  I no longer drink alcohol

How many times in the last year have you had more than 5 drinks (male)/4 drinks (female) in one day? \_\_\_\_\_

**I'm interested in talking more about my alcohol use**

Have you ever smoked or chewed tobacco or smoked marijuana?  No  Yes  Current: \_\_\_\_\_ per day

**I'm interested in help to stop using** \_\_\_\_\_

Do you use illicit drugs?  No  Yes  **I'm interested in help to stop using** \_\_\_\_\_

Do you ever take prescription drugs for non-medical reasons?  No  Yes

If yes, how often?  Once or Twice  Monthly  Weekly  Daily or Almost Daily

**I'm interested in talking more about prescription drug use**

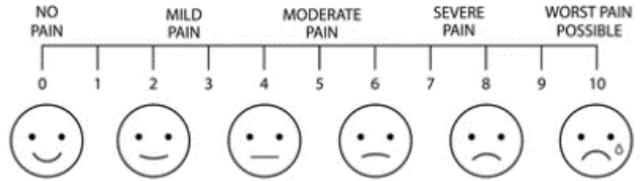
## Pain Assessment

Is the pain constant?  Yes  No

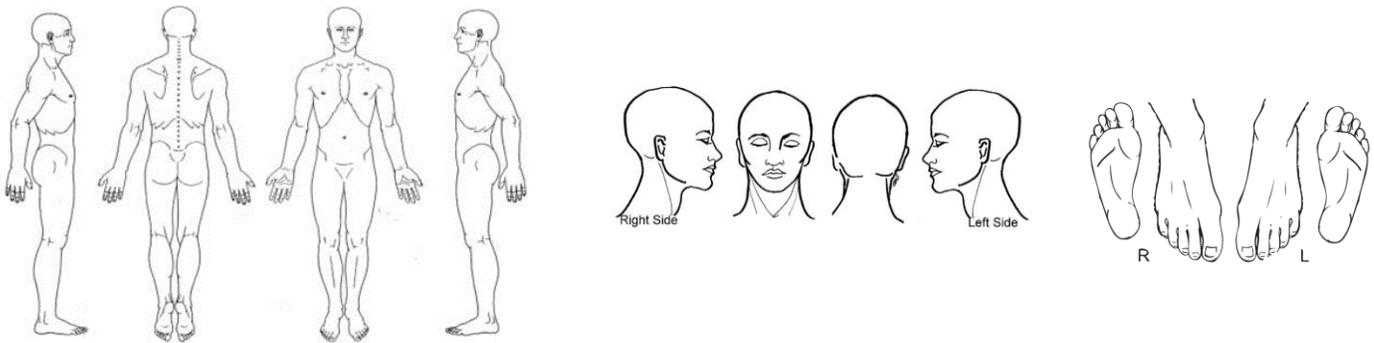
Type of pain:  Ache  Deep  Sharp  Hot  Cold  Sensitive skin  Other: \_\_\_\_\_

Onset, duration, and variation: \_\_\_\_\_

Intensity: on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine, how is your pain right now?



Mark location of pain on diagrams below:



What relieves the pain? \_\_\_\_\_

I'm interested in other options to manage my pain:  Yes  No

Do you see a specialist to manage your pain?  Yes  No Specialist: \_\_\_\_\_

Do you have a prescription for pain medication?  Yes  No

If yes,  Post-surgery (short term) or  Chronic pain

If you have a prescription for pain management, please complete:

Mark each box that applies	Female	Male
<b>Family history of substance abuse</b>		
Alcohol	1	3
Illegal Drugs	2	3
Rx Drugs	4	4
<b>Personal history of substance abuse</b>		
Alcohol	3	3
Illegal Drugs	4	4
Rx Drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
<b>Psychological disease</b>		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

**Health Screenings:**

Do you have trouble with speech?  Yes  No

Do you have trouble hearing?  Yes  No      Do you wear a hearing aid?  Yes  No

Last hearing exam: \_\_\_\_\_

Do you have trouble seeing?  Yes  No      Do you wear glasses or contacts?  Yes  No

Most recent diabetic retina (dilated) eye exam:  I'm not a diabetic

- Mo/Yr \_\_\_\_/\_\_\_\_
- By Dr. \_\_\_\_\_ Ophthalmologist / Optometrist (please circle one)
- Location (name of eye doctor's office, if known) \_\_\_\_\_
- Result of retina exam \_\_\_\_\_ (e.g., negative for retinopathy)

**When was your most recent:**

Mammogram: Mo/Yr: \_\_\_\_\_ Where: \_\_\_\_\_ Result: \_\_\_\_\_

Colonoscopy: Mo/Yr: \_\_\_\_\_ Where: \_\_\_\_\_ Result: \_\_\_\_\_

I elected another colon test:  FIT-DNA year \_\_\_\_\_ Result: \_\_\_\_\_

FOBT year \_\_\_\_\_ Result: \_\_\_\_\_

Other colon screening: \_\_\_\_\_ Yr. \_\_\_\_\_ Result: \_\_\_\_\_

Osteoporosis Screening (DEXA) bone scan:

- Mo/Yr \_\_\_\_/\_\_\_\_ Location: \_\_\_\_\_ (Name of imaging center)
- I received my bone scan in my home

I have a:  Living will     Medical Order for Life Sustaining Treatment (MOST)

Medical Power of Attorney     Other: \_\_\_\_\_

**I'm interested in learning more about documenting my wishes for end-of-life decision-making**

I'd like to talk with a Care Coordinator about \_\_\_\_\_.

A Care Coordinator can assist with managing chronic diseases like diabetes, heart failure and COPD. They can help find options for: reducing cost of medications, transportation, long-term care planning, caregiver support, end of life decision-making, resources for mental health or substance abuse.

\_\_\_\_\_ Provider Signature (reviewed)

No cognitive issues detected     Cognition screen prompts Mini-Cog or SLUM, results and plan in visit note.

For Office Use Only

Referral to Care Coordinator completed \_\_\_\_\_ (initials)

Personalized Preventive Plan of Services (PPPS) completed and given to patient: \_\_\_\_\_ (initials)