Health Risk Assessment Questionnaire

PLEASE PRINT

Name: ____Dob:_____________________________Date:__________________

Medical history: Please indicate any of the following illnesses you have had in the past year

_______Abdominal pain
_______Agitation
_______Anemia
_______Bladder dysfunction
_______Bleeding
______Blurred vision
______Breast lump
______Change in bowel habit
______Chest pain
______Constipation
______Cough
______Diarrhea
______Difficulty concentrating
______Difficulty sleeping
_______Dizziness

______ Ear pain
______ Edema
______ Fatigue
______ Fever
______Headache
______Hoarseness
______Hypertension
______Indigestion
______ Injury
______Joint pain
______Low back pain
______Memory loss
______Menstrual irregularities
______Myalgia
_______Nausea

_____Neck pain
_____Night sweats
_____Nightmares
_____Pain
_____Palpitations
_____Pelvic pain
_____Rash
_____Skin lesions
_____Stress
______Urinary frequency
______Vaginal discharge
______Visual disturbance
______Vomiting
______Weight loss
______Weight gain

Other ____

Any Changes in your p**ersonal medical history?** _____Yes ______No Explain____

Any new or changed a**llergies:** YES [ ] NO [ ] ____

Any changes or new m**edications**: see medication list.

Any Changes in your f**amily medical history**? ______Yes _______No Explain____

SOCIAL ACTIVITY

Do you smoke? _______never smoked _______former smoker.

How many cigarettes/ packs do you smoke a day?____ __

How many years did you smoke for? ____.

Alcohol use: _______none ______occasional use (1-2 glasses beer/wine a week) _______ moderate use

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Caffeine use: how many servings of coffee a day _________? How many servings of tea a day____________?

Carbonated beverages how many servings a day _________?

Do you use Illiciate drugs? _______no drug ______some drug use

My (nutrition) diet is: _____ balanced _____ some what- balanced _______well- balanced

I am: ______married _____divorced _____separated ______widow other ____________________

My current living situation is: _____alone _____spouse ______family other ____________________

Current work/student status: _____retired _____ full time _____ part time

Most recent occupation: (teacher,nurse ect) ____

Do you have any financial concerns that would affect your healthcare? ________yes _______no

Other ____

Home location: _____I live in the city _____rural area other __________________________________

Type of home I live in. _____house ____apartment _____assisted Living _____nursing home ____shelter

Other:____

Seat belt use _____always _____ never ____ occasional _______ use when riding in a car

Helmet use. _____always _____ never ____occasional _______use while riding a bike/motorcycle

Sunscreen: _____ always _____never ____occasional _______currently using

Recent hospitalizations? Yes [ ] No [ ] which hospital? ____

date: ____ **reason:** ____

Please list all doctors/providers/durable equipment company you see:

OVERALL HEALTH STATUS

How do you feel? ____excellent ___very good ___good ____fair ___poor ___improving ____declining

Advance care planning: Do you have an advanced directive in place? ____Yes, I have one in place ____No, I don't' have one in place

My h**earing** is? ____excellent ___very good ___good ___fair ____improving ____declining

My **dentition (teeth)** is? ____excellent ___very good ___good ___fair ____poor

____I wear dentures ____partials Other____

How much pain have you experienced in the last 7 days? ______none _____some pain ___________a lot of pain

Are you confident in managing your own healthcare?

_____I am confident managing my health _____somewhat confident ______not very confident

Physical activity comparison ______I am more active than last year _____same ___________ less active

In the last 4 weeks the amount of physical activity I could tolerate for more than 2 minutes was?

________light ________very light __________moderate ________heavy ______none

Do you exercise more than 3 days a week for at least 20min? ________I do ______I do not

Are you a diabetic? ______ **n**ot a diabetic _______dabetes mellitus type II ______diabetes mellitus type I

Most recent HbA1c level? ______unknown _______not sure last level was.______________________________

My appetite has been. ______normal ______decreased ______ increased

Sleep pattern: I sleep how many hours per night? ____

Problems with elimination. ____I have none ____urinary frequency ____ urinary incotinence

____constipation ____ diarrhea

Safety measures I have at home. ______smoke detector ______carbon monoxide detector

Emotional problems I'm having trouble with : _____none _____anxiety _____apprehension

_____depression _____ nervousness _____sleep disturbance

IMPAIRMENTS (check all that apply)

________ balance disorder _______blindness ______color blindness ______partial blindness ______deafness

________hearing loss ______dependent on cane ______handicap place card ______wheelchair bound

FUNCTIONAL DAILY ACTIVITIES (check appropriate answer)

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

__________no help _________yes, sometimes _________ yes, always

PLEASE LIST INDIVIDUAL WHO HAS HELPED YOU: ____

In the last 4 weeks have you had trouble doing any of the following?

Take medications: ________no difficulty ________yes, sometime ______ yes required assistance.

Getting around the home _________no difficulty ________yes, sometimes ______yes, required assistance.

Bathing and dressing _________no difficulty ________yes, sometimes ______yes, required assistance.

Using the telephone ________ no difficulty _________yes, sometimes ______yes, required assistance.

Traveling ________ no difficulty _________yes, sometimes ______yes, required assistance.

Grocery shopping ________ no difficulty _________yes, sometimes ______yes, required assistance

Preparing meals ________ no difficulty _________yes, sometimes ______yes, required assistance.

Housework ________ no difficulty _________yes, sometimes ______yes, required assistance.

Managing money ________ no difficulty _________yes, sometimes ______yes, required assistance.

Driving a motor vehicle ________no difficulty ________yes, sometimes ______yes, required assistance

DEPRESSION QUESTIONNAIRE (Check appropriate answer)

OVER THE PAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING PROBLEMS?

Little interest or pleasure in doing things:

________not at all ________several days _________more the half the days _________nearly every day

Feeling down, depressed or hopeless.

________not at all ________several days _________more the half the days _________nearly every day

Trouble falling asleep, staying asleep, or sleeping too much?

________not at all ________several days ________more the half the days _________nearly every day

Feeling tired or little energy:

_______ not at all _______several days _______more the half the days ________nearly every day

Poor appetite or overeating:

_______ not at all _______several days ________more the half the days ________nearly every day

Feeling bad about yourself or that you: are a failure or have let yourself or your family down.

_________ not at all _______several days _______more than half the days ________nearly every day

Trouble concentrating on things (reading, watching TV)

_______not at all ________several days _______more the half the days _______nearly every day

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.

______not at all ________several days ________more than half the days _______nearly every day

Thoughts you would be better off dead, or hurting yourself in some way?

_______not at all _______several days _______more the half the days ______nearly every day

FALL ASSESMENT

History of falling: ________ immediate or ________ within 3 months

(Secondary Diagnosis)____

Any use of ambulatory aids: ______bed rest/nurse assist _____cane/walker/crutches ______ furniture

Presence of an IV/Hep Lock**?** ______Yes ____No

How is your gait/ transferring capability? ______normal/bed ____rest/immobile ____weak _____impaired

How your mental status? _____oriented to own ability ____forget limitations

HEALTH MAINTENANCE HISTORY

Preventive type **Date completed:**

Annual eye exam: ______________________________

Alcohol misuse counseling and screening: ______________________________

Bone density study: ______________________________

Breast cancer (mammogram) screening: ______________________________

Blood glucose (diabetes) screening: ______________________________

Cervical and vaginal screening:______________________________

Cholesterol (lipid) panel: ______________________________

Depression screening: ______________________________

Echocardiogram: ______________________________

Colonoscopy screening (colorectal cancer) ______________________________

Dental exam: ______________________________

Flu vaccine: ______________________________

Glaucoma test: ______________________________

Hepatitis B vaccine: ______________________________

Hepatitis C testing: ______________________________

HIV screening: ______________________________

Medication nutrition therapy services: ______________________________

Pneumovax (Pneumococcal): ______________________________

Shingles vaccine: ______________________________

Tetanus vaccine: ______________________________

Tobacco screening (counseling):______________________________

Signature: ______________________________

Date: ______________________________