Do not write, stamp, punch holes or affix a sticker in this area.

* Health Risk Assessment *

Please answer every question

To reproduce, follow the printing instructions.
Do not fold this form.

PLEASE PRINT PATIENT'S LAST NAME

Marking Instructions

Please use a #2 pencil. Fill in the complete oval as shown...

FIRST NAME

DATE OF BIRTH

Month Day Year

How would you rate your overall health? (Please select one.)

poor good fair excellent

	Yes	No
Have you had any problems with balance or falling (within the last 3 months)?		
Do you exercise regularly or take part in a regular exercise program?		
Do you have difficulty getting to doctor's appointments or other medical services?		
Have you had a dental visit in the past 12 months?		
Do you have family or friends available to support you when needed?		
Do you have problems with memory or understanding instructions?		
Do you currently smoke or use tobacco?		
Have you had a flu shot in the last 12 months?		
Any recent vision changes?		
Any recent hearing changes?		
Have you had problems with urine leakage?		

Do you use any of the following to get around? (Select all that apply.)

cane prosthetic device
walker power operated vehicle (scooter)
wheelchair **NONE**

What health conditions do you currently have? (Please mark each condition that applies to you.)

heart failure or an enlarged heart heart disease breathing problems caused by emphysema or asthma
diabetes or other blood sugar problems kidney dialysis
other conditions depression **NONE**

What is your smoking status? current (every day) current (some days) previous never

How many packs per day do you (or did you) **smoke?** less than 1 1-2 more than 2

How many years have you (or did you) **smoke?** less than 5 5 10 15 20 25 30 35 40+

Do you have any trouble completing the following activities?	No Trouble	Need Some Help	Need Help
Bathing			
Getting dressed			
Shopping for groceries			
Meal preparation			
Housework			
Laundry			
Taking or getting medications			
Handling finances			
Toileting			
Using the telephone			
Feeding yourself			

If you have pain, on a scale of 1-10, what is your normal pain level? (0 = no pain, 10 = the most pain you have felt)

☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Over the <u>past two weeks</u> how often have you been <u>bothered by</u> the following problems?	Not at all ☺	Several days ☺	More than half of the days ☹	Nearly every day ☹
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				

For technical support, please contact PatientLink at Support@MyPatientLink.com.