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# Health Risk Assessment

Please answer every question

STAFF: Handwritten items must be entered **MANUALLY**.

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
- fair
- good
- excellent

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

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

please fold on dotted line

How many different prescriptions do you take each day?

- 0
- 1-3
- 4-6
- 7-10
- 11 or more

Do you have any trouble getting around at home or outside your home?

- yes  no

Do you need the help of another person to move around inside or outside your home?

- yes  no

Do you live alone?

- yes  no

Do you need to stay in the house most or all of the time?

- yes  no

Do you need help at home due to your health problems?

- yes  no

Has it been hard for you to get the help you need?

- yes  no

In the previous 12 months, have you stayed overnight as a patient in the hospital?

- yes  no

About how many times?

- 1 time
- 2-3 times
- 4 or more times

In the previous month, have you gone to an urgent care or emergency room?

- yes  no

please fold on dotted line

Over the past two weeks how often have you been bothered by the following problems?

	Not at all 	Several days 	More than half of the days 	Nearly every day 
Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling nervous, anxious, or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have difficulty getting to doctor's appointments or other medical services?

- yes  no

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Have you had any problems with balance or walking?  yes  no

Are you physically active? (e.g., walking, group classes, stationary bike, etc.)  yes  no

Have you fallen (without having been pushed) in the last 3 months?  yes  no

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 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+

Have you had a flu shot in the last 12 months?  yes  no

----- please fold on dotted line -----

Any recent vision changes?  yes  no

Any recent hearing changes?  yes  no



Have you had problems with urine leakage?  yes  no

Have you had any problems with your short-term memory? (e.g., What did you have for dinner last night?)  yes  no

Have you had any problems with your long-term memory? (e.g., Where were you born?)  yes  no

Do you have trouble understanding instructions?  yes  no

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 

Do you have any trouble completing the following activities?

----- please fold on dotted line -----

	No Trouble	Need Some Help	Need Help
Bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting dressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to and from the toilet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preparing meals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeding yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using the telephone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Housekeeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Laundry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Managing medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Managing household finances	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>