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Healthcare for your entire family...

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We listen, We help, We understand, but most importantly, We CARE!

Health Risk Assessment

Patient Name_____ **Patient DOB**_____

Please list all chronic conditions:

_____

_____

_____

_____

List all current medical providers and suppliers:

Physician Name	Specialty	Phone Number

List Your Medications and Dosages (Include vitamins and over the counter medications:

Medication Name	Dose	Frequency	

Fall Risk:

1. Have you fallen in the past 6 months? Yes____ No____
2. Do you use a walker or cane? Yes____ No____
3. Do you steady yourself by holding onto furniture when you walk? Yes____ No____
4. Are you wheelchair bound? Yes____ No____

Activities of Daily Living:

1. Do you need assistance with the following tasks?
   Bathing/Grooming: Yes____ No____
   Eating: Yes____ No____
   Dressing: Yes____ No____
   Walking: Yes____ No____
   Transferring: Yes ____ No____
   Using Toilet: Yes____ No____
2. Do you have support in the following ways? Emotional_____ Transportation____
   Housekeeping____ Finances____ Guidance____

Advanced Care Planning:

1. Do you have an Advanced Directive? Yes____ No____
   A. Living Will ____ **B.** 5 Wishes____ **C.** DNR____

Pain Assessment:

1. Are you having any pain? Yes____ No____
2. On a scale of 0 to 10, How would you rate your pain? (0 being no pain 10 being severe pain) _____
3. Where is the pain located? _____

Nutrition Assessment:

1. Has your food intake declined over the past 3 months due to loss appetite, digestive problems, chewing or swallowing difficulties? Yes____ No____
2. Has there been any significant weight loss in the last 3 months? Yes____ No____

Hospitalizations:

1. How many visits have you had to the Emergency Room in the past year? _____
2. How many times have you been admitted to the Hospital in the past year? _____

Depression Screening

Over the last 2 weeks, how often have you been bothered by any of the following problems	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off 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?

Somewhat difficult	Very difficult	Extremely difficult

Health Maintenance Checklist

Colon Cancer Screening:

Colonoscopy Date: _____
Name of Doctor _____
City/State _____
Sigmoidoscopy Date: _____
CT Colonography Date: _____
Stool Card (IFOBT) Date: _____
FIT-DNA (cologuard) Date: _____

Mammogram Date: _____
Name of Imaging Center _____

Diabetic Care:

Diabetic Eye Exam Date: _____
Name of Doctor _____
A1C Date _____
Urine Microalbumin Date _____
Diabetic Foot Exam Date_____
Are you currently taking statin drugs? _____

Bone Density Date:
Name of Imaging Center_____

Immunization Dates:
Influenza_____
Pneumovax_____
Prevnar 13 _____
TDAP _____

Alcohol Questionnaire

1. Do you have a drink containing alcohol in the past year? **Yes____ No___**
    - **If Yes:** How often did you have a drink containing alcohol in the past year?
        A. Never
        B. Monthly or less
        C. 2 to 4 times a month
        D. 2 to 3 times a week
        E. 4 or more times a week
    - **If Yes:** How many drinks did you have on a typical day when you were drinking in the past year?
        A. 1 or 2 drinks
        B. 3 or 4 drinks
        C. 5 or 6 drinks
        D. 7 to 9 drinks
        E. 10 or more drinks
    - **If Yes:** How often did you have 6 or more drinks on one occasion in the past year?
        A. Never
        B. Less than monthly
        C. Monthly
        D. Weekly
        E. Daily or almost daily

Tobacco Questionnaire

Are you a current, former, or nonsmoker? _____

If current smoker: How often do you smoke cigarettes?

A. Every day
B. Some days, but not every day

If current smoker: How many cigarettes a day do you smoke? _____

A. 5 or less
B. 6-10
C. 11-20
D. 21-30
E. 31 or more

If current smoker: How soon after you wake up do you smoke your first cigarette?

A. Within 5 minutes
B. 6-30 minutes
C. 31-60 minutes
D. After 60 minutes

If current smoker: Are you interested in quitting?

A. Ready to quit
B. Thinking about quitting
C. Not ready to quit

Additional Findings: Tobacco User

Please circle if one of the following applies:

A. Chain smoker
B. Chews tobacco
C. Pipe smoker
D. Snuff user
E. Cigar smoker