Annual Health Risk Assessment

Date ______________________ Date of birth ______________________

Name ______________________ Name Listed with Insurance (if different) ______________________

Pronouns ______________________

General Health

General Health	
Form completed by:	☐ Self ☐ Friend/Family ☐ Clinic Staff ☐ Other
How do you rate your overall health?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Do you have a dentist you see regularly?	☐ Yes ☐ No
How many times in the last sixmonths have you been to the emergency room?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+
How many times in the last six months have you been admittedto the hospital?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+
Rate your pain on a scale of 0-10, where 0 means no pain at all and 10 means the worst pain imaginable.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Allergies and Reactions

Allergies and Reactions	
Medication	Name(s): ☐ None Reaction(s):
Foods	Name(s): ☐ None Reaction(s):
Insects/Animals	Name(s): ☐ None Reaction(s):

Medications	
Do you take any over-the-counter medication (vitamins, supplements, herbal medicines)?	☐ Yes ☐ No
How many times in the last month have you missed taking your medications?	________ times ☐ I do not take medications
How many times in the last month have you taken your medications differently than prescribed by your doctor?	________ times ☐ I do not take medications
Do you have enough money to pay for the medications, medical supplies, and medical visits you need?	☐ Yes ☐ No

Nutrition	
How many servings of fruit and vegetables do you usually eat each day?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7
How many servings of fiber or whole grain foods do you usually eat each day?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7
How many servings of meat, fish, or other protein do you usually eat each day?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7
How many times do you eat fast food during the week?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7
How many times during the week do you reduce the size of your meals or skip meals because you don't have enough money, or enough help to shop or cook?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7

Physical Activity	
How many days a week do you exercise?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't exercise
On the days you exercised, how long did you exercise?	☐ 0-30 min ☐ 30 min – 1 hour ☐ More than 1 hour ☐ I don't exercise
What kind of exercise routine do you have?	☐ Light (walking, stretching) ☐ Heavy (jogging, swimming) ☐ Routine activities (cleaning, gardening, shopping) ☐ I don't exercise

Tobacco Use	
Do you use tobacco or nicotine products (cigarettes, e-cigarettes, smokeless tobacco, cigars, or pipes)?	☐ Yes ☐ No If yes, how any packs/time per day? ______________ How many years? ______________
Are you interested in quitting?	☐ Yes ☐ No
Have you had a lung cancer screening?	☐ Yes ☐ No

Alcohol Screening	
Have you ever felt you should cut down on your drinking?	☐ Yes ☐ No
Have people annoyed you by criticizing your drinking?	☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking?	☐ Yes ☐ No
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?	☐ Yes ☐ No

SCORE:

Fall Risk	
Have you had any problems with balance or walking in the last year?	☐ Yes ☐ No
Have you had more than one fall in the last year?	☐ Yes ☐ No
Have you had an injury from a fall in the last year?	☐ Yes ☐ No

Social Support	
What is your current living situation?	☐ House/apartment (stable) ☐ With friends/family (temporary) ☐ In a shelter ☐ In a hotel since: ☐ In a vehicle ☐ On the street
Who do you live with?	
Which of the following applied to you?	☐ I have a supportive family ☐ I have supportive friends ☐ I participate in church, clubs, or other activities ☐ None
How often do you get out and meet with family and friends?	☐ Often ☐ Sometimes ☐ Almost Never ☐ None
Do you have transportation to medical appointments?	☐ Yes ☐ No
In the last 12 months, have you needed to see a doctor but could not because of cost?	☐ Yes ☐ No
In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	☐ Yes ☐ No
Do you need help reading hospital or clinic material?	☐ Yes ☐ No
Do you or your caregiver have enough help with resources or caregiving duties? (Skip, if you do not give or receive care)	☐ Yes ☐ No
Is anybody mistreating you physically or financially?	☐ Yes ☐ No

If you answered yes, to any of these questions would you like to receive assistant with any of these needs?	☐ Yes ☐ No
Are any of your needs urgent? For example, I don't have food tonight or I don't have a place to sleep tonight.	☐ Yes ☐ No

Depression Screening *In the last two weeks, how often have you been bothered by any of the following problems?*	
Little interest or pleasure in doing things	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling down, depressed, or hopeless	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Depression Screening continued *In the last two weeks, how often have you been bothered by any of the following problems?*	
Trouble falling asleep or sleeping too much	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling tired or having little energy	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Poor appetite or overeating	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling bad about yourself or that you're 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 such as reading the newspaper or watching television	☐ Not at all ☐ Several days ☐ More than 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've 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 of hurting yourself	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
If you checked off any problems in this section, how difficult have these problems made it for you to do your work, take care of things at home or get along with others?	☐ Not at all ☐ Somewhat difficult ☐ Very difficult

SCORE:

Domestic/Intimate Partner Violence	
Do you feel safe with people you live or spend time with?	☐ Yes ☐ No
Are you afraid to go home?	☐ Yes ☐ No
Has anyone forced you to have sexual activities recently?	☐ Yes ☐ No
Interventions	
I would like to learn more	☐ Yes ☐ No
I am not interested at this time	☐ Yes ☐ No

Colorectal Cancer Screening *(all patients, age 45-75 years)*	
Have you had a fecal immunochemical (FIT) test in the last year? (FIT test: detects for human blood in your stool sample)	☐ Yes ☐ No
Have you had a colonoscopy in the last 10 years?	☐ Yes ☐ No ☐ Not sure

Breast Cancer Screening *(all women ages 50-74 years)*	
Have you had a mammogram within the last year?	☐ Yes ☐ No ☐ Not sure

Cervical Cancer Screening *(all women ages 21-65)*	
Have you had a pap smear within the last 3 years?	☐ Yes ☐ No ☐ Not sure

Advance Care Planning	
Have you discussed who in your family would make decisions about the care you would want to receive if you become unable to speak for yourself?	☐ Yes ☐ No
Do you have a health care power of attorney or a living will?	☐ Yes ☐ No
Would it be okay if we discussed this further with you today?	☐ Yes ☐ No

Your Medical History *(check if you have had any of the following conditions)*

☐ Alcoholism	☐ Diabetes HbA1C & Date ____________	☐ Mental Illness
☐ Anemia	☐ Glaucoma	☐ Chronic Pain ☐ Opioid Use
☐ Asthma	☐ Hearing Loss	☐ Osteoporosis
☐ Arthritis	☐ Heart Attack	☐ Physical Disability
☐ Bladder Problems	☐ Heart Disease ☐ Statin Therapy	☐ Seasonal Allergies
☐ Blindness	☐ Heart Failure	☐ Seizure Disorder
☐ Blood Clots	☐ Hepatitis	☐ Sleep Disorder
☐ Breast Cancer	☐ High Cholesterol ☐ Statin Therapy	☐ Stomach Disorder
☐ COPD	☐ Hypertension	☐ Stroke
☐ Colon Cancer/Polyps	☐ Irregular Heartbeat	☐ Thyroid Disease
☐ Cancer – Other	☐ Kidney Disease	☐ Tuberculosis
☐ Depression	☐ Liver Disease	☐ Ulcer

Your Family's Medical History *(check if a relative has or have had one of these conditions)*

☐ Alcoholism	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Alzheimer's	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Dementia	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Breast Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Colon Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Prostate Cancer	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Cancer (Other)	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Diabetes	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Mental Illness	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Hypertension	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Heart Attack	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Osteoporosis	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Seizures	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling
☐ Stroke	☐ Father	☐ Mother	☐ Grandparent	☐ Sibling

Sexual Health History

What is your gender? What is your assigned gender at birth if different?	
What is your sexuality?	☐ Heterosexual (straight) ☐ Gay/lesbian ☐ Bisexual ☐ Other (please list):
What is your current relationship status?	☐ Single ☐ Married ☐ Divorced/separated ☐ Widowed ☐ Partnered ☐ Other (please list):
What is the gender of your partner(s)?	
How do you practice "safer sex" (condoms, monogamy, STD testing, etc.)?	
Have you ever been diagnosed or treated for a sexually transmitted infection?	☐ Yes ☐ No Name/date/treatment:
Have you ever had a menstrual period? Age at 1st period? Date last menstrual period began?	☐ Yes ☐ No (skip this section) Age: Date:
Are you capable or have you ever been capable of becoming pregnant? Have you ever been pregnant? Do you use any kind of birth control? Have you or are you currently going through menopause?	☐ Yes ☐ No (skip this section) ☐ Yes ☐ No If yes, how many times: How many births: Type: ☐ Yes ☐ No ☐ Unsure If yes, what age:

Past Surgeries

List of Medicines and Supplement, you take	
Name if medicine/supplement	Dose and frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Other Health Care Providers	
Provider Name	Specialty

Medical Equipment and Suppliers	
Type of Medical Equipment (examples: oxygen tank, etc.)	Name of Supplier