

Annual Health Risk Assessment (EST)

**Date:** Click or tap here to enter text. **Date of birth:** Click or tap here to enter text.

**Name:** Click or tap here to enter text. **Name Listed with Insurance (if different):** Click or tap here to enter text.

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| --- |
| **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 Dentist Name: Click or tap here to enter text. |
| 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 |
| Has your Medical History Changed in the past year?  | [ ]  Yes; New condition:Click or tap here to enter text. [ ]  No  |
| Have you had surgery or been hospitalized in the past year? | [ ]  Yes; Please explain:Click or tap here to enter text. [ ]  No  |
| Has you Family Medical History changed in the past year? | [ ]  Yes; New condition:Click or tap here to enter text. [ ]  No  |
| Has your Sexual Health History changed in the past year? | [ ]  Yes; Please explain: Click or tap here to enter text. [ ]  No  |
| Has your physical activity changed in the past year? | [ ]  Yes; Please explain: Click or tap here to enter text. [ ]  No  |
| Has your nutrition changed in the past year? | [ ]  Yes; Please explain: Click or tap here to enter text. [ ]  No  |
| Have you established care with any providers within the past year? (Specialists, Naturopath, Chiropractor) | [ ]  Yes; Who?Click or tap here to enter text. [ ]  No  |
| Have you received any new medical equipment in the past year? (cane, oxygen, glucometer) | [ ]  Yes; What?Click or tap here to enter text. [ ]  No  |
| Do you have any medication allergies? | [ ]  Yes [ ]  No Allergy: Click or tap here to enter text.Reaction: Click or tap here to enter text.Allergy: Click or tap here to enter text. Reaction: Click or tap here to enter text. |
| Please list your Medications (include strength and frequency). | 1. Click or tap here to enter text.
2. Click or tap here to enter text.
3. Click or tap here to enter text.
4. Click or tap here to enter text.
5. Click or tap here to enter text.
6. Click or tap here to enter text.
7. Click or tap here to enter text.
8. Click or tap here to enter text.
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| **Tobacco / Vaping Use** |
| Have you ever used tobacco? | [ ]  Yes [ ]  NoIf yes, how any packs/time per day? Click or tap here to enter text.How many years? Click or tap here to enter text. |
| Have you used tobacco in the last 30 days? | [ ]  Yes [ ]  NoIf yes, how any packs/time per day?Click or tap here to enter text. |
| Have you ever tried to quit using tobacco? | [ ]  Yes [ ]  No Quit Date: Click or tap here to enter text. |
| Have you ever used tobacco or nicotine products (cigarettes, e-cigarettes, smokeless tobacco, cigars, or pipes)? | [ ]  Yes [ ]  No |
| Do you vape? | [ ]  Yes [ ]  NoIf yes: what device? Click or tap here to enter text.How often? Click or tap here to enter text. |
| **Alcohol Screening** |
| Do you drink alcohol? | [ ]  Yes [ ]  No [ ]  Former Quit Date: Click or tap here to enter text. |
| What type of alcohol? | [ ]  Beer & Liquor [ ]  Beer & Wine [ ]  Beer[ ]  Hard Liquor [ ]  Wine [ ]  Other: Click or tap here to enter text. |
| Frequency? | [ ]  Daily [ ]  Occasionally [ ]  Rarely [ ]  Socially [ ]  Other |
| Amount? | Number of beers: Click or tap here to enter text.Number of glasses: Click or tap here to enter text.Number of packs: Click or tap here to enter text.Number if pints or bottles: Click or tap here to enter text. |
| How many times in the past year, have you had 4 or more drinks in a day? | [ ]  None [ ]  1-2 [ ]  3-5 [ ]  > 5 |
| **Domestic/Intimate Partner Violence** |
| Within the past year, or since you have been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? | [ ]  Yes [ ]  No |
| Are you in a relationship with a person who threatens or physically hurts you? | [ ]  Yes [ ]  No |
| Has anyone forced you to have sexual activities that made you feel uncomfortable? | [ ]  Yes [ ]  No |
| **Social Support** |
| What is your current living situation? | [ ]  Stable/Permanent [ ]  Temporary [ ]  Unknown [ ]  Unstable [ ]  In a vehicle, on the street, in a hotel, other |
| Who do you live with?  | Click or tap here to enter text. |
| Which of the following apply to you? | [ ]  I have a supportive family[ ]  I have supportive friends[ ]  I participate in church, clubs, or other activities[ ]  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 or your caregiver have enough help with resources or caregiving duties? (Skip, if you do not give or receive care) | [ ]  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 |
| **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 # of falls: Click or tap here to enter text. |
| Have you had an injury from a fall in the last year? | [ ]  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  |
| 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**TOTAL SCORE\_\_\_\_\_\_\_** |
| **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 [ ]  Not sureDate: Click or tap here to enter text.Location: Click or tap here to enter text. |
| Have you had a colonoscopy in the last 10 years? | [ ]  Yes [ ]  No [ ]  Not sureDate: Click or tap here to enter text. Location: Click or tap here to enter text. |
| **Breast Cancer Screening** *(all women ages 40-74 years)* |
| Have you had a mammogram within the last year? | [ ]  Yes [ ]  No [ ]  Not sure Date: Click or tap here to enter text.Location: Click or tap here to enter text. |
| **Cervical Cancer Screening** *(all women ages 21-65)* |
| Have you had a pap smear within the last 3-5 years? | [ ]  Yes [ ]  No [ ]  Not sureDate: Click or tap here to enter text.Location: Click or tap here to enter text. |