

Annual Health Risk Assessment (New Patient)

**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.

**Preferred Pronouns:** 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 |
| 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.  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. 9. Click or tap here to enter text. |

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| --- | --- | --- | --- | --- | --- |
| **Your Medical History** *(check if you have had any of the following conditions)* | | | | | |
| Allergies  Anemia  Angina  Anxiety  Arthritis  Asthma  Atrial Fibrillation  Autoimmune Disease  Blood clots  Cancer  Type :Click or tap here to enter text.  Cardiac Arrythmias | COPD  Coronary Artery Disease  Depression  Type 1 Diabetes  Type 2 Diabetes  High Cholesterol  Statin Therapy  Gallbladder Disease  GERD (Acid Reflux)  Headache/Migraines  Heart Disease  Statin Therapy  Heart Valve Disorder  Hepatitis / Liver Disease | | | | Hypertension  Irritable Bowel Disease  Myocardial Infarction  (Heart Attack)  Osteoporosis  Renal Disease  Seizure Disorder  Stroke  Thyroid Disease  Tuberculosis  Chronic Pain  Opioid Use |
| **Past Surgeries / Recent Hospitalizations (include emergency room and urgent care visits)** | | | | | |
| Click or tap here to enter text. | | | | | |
| Click or tap here to enter text. | | | | | |
| Click or tap here to enter text. | | | | | |
| **Your Family’s Medical History** *(list the conditions your family has/had)* | | | | | |
| Father  Mother  Grandparent(s)  Which: Click or tap here to enter text.  Sibling(s)  Which:Click or tap here to enter text.  Unknown/Adopted  No relevant family history | cancer  Diabetes  Hypertension  Other  Please explain: Click or tap here to enter text.  cancer  Diabetes  Hypertension  Other  Please explain: Click or tap here to enter text.  cancer  Diabetes  Hypertension  Other  Please explain: Click or tap here to enter text.  cancer  Diabetes  Hypertension  Other  Please explain: Click or tap here to enter text. | | | | |
| **Tobacco / Vaping Use** | | | | | |
| Have you ever used tobacco? | | | Yes  No  If 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  No  If 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  No  If 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 Date quit: Click or tap here to enter text. | | |
| What type(s) 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 of 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 | | | |
| **Sexual Health History** | | | | | |
| What is your current gender? | | | Female  Male  Undifferentiated  Unknown | | |
| What was your assigned gender at birth? | | | Female  Male  Undifferentiated  Unknown | | |
| What is your gender identity? | | | Female  Male  Transgender Male  Transgender Female  Gender Queer  Additional Gender Category/Other: \_\_\_\_\_\_\_\_\_\_  Choose not to disclose | | |
| What is your sexual orientation? | | | Heterosexual (straight)  Gay/lesbian  Bisexual  Choose not to disclose  Don’t Know / Other | | |
| What is your current relationship status? | | | Single  Married  Divorced/separated  Widowed  Partnered  Other (please list): | | |
| Are you sexually active? | | | Yes  No  Previously | | |
| Number of current partners?  Number of lifetime partners? | | | Click or tap here to enter text.  Click or tap here to enter text. | | |
| Have you ever had sexual intercourse? | | | Yes, Last 3 months  Yes, Last 12 months  No, never | | |
| Do you practice safe sex? | | | Yes  No  Condom  Monogamy  Other Click or tap here to enter text. | | |
| Do you use birth control?  What type? | | | Yes  No If no, reason: Click or tap here to enter text.  Condom  Oral/Patch/Ring Contraceptive  Implant/Device  Abstinence  Sterilization  Other (please list) Click or tap here to enter text. | | |
| **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 | | |
| **Physical Activity** | | | | | |
| What is your activity level? | | | Sedentary  Moderate  Vigorous | | |
| Are you a health club member? | | | Now  Previously  Never | | |
| What type of exercise do you do? | | | Type: Click or tap here to enter text.  I don’t exercise | | |
| How often do you exercise? | | | Daily  2-3x/week  4-5x/week  Never  Occasionally | | |
| **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 | | |
| **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 | | |
| Do you have adequate access to water to stay hydrated? | | | 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 | | |
| **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  Date: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 sure  Date: 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 sure  Date: Click or tap here to enter text.  Location: Click or tap here to enter text. | | | |
| **Other Health Care Providers** | | | | | |
| Provider Name | | | | Specialty | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | |
| **Medical Equipment and Suppliers** | | | | | |
| Type of Medical Equipment  (examples: oxygen tank, etc.) | | | | Name of Supplier | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | |