Adult Health Risk Assessment

Date: ____________________ **Date of Birth:** ____________________

Name: ______________________________ **Preferred Pronouns (optional):** ____________________

General Health	
Form completed by:	☐ Self ☐ Friend/Family ☐ Clinic Staff ☐ Other
How do you rate your overall health?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Rate your pain on a scale on 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 use opioids to control your pain? (Examples: morphine, methadone, oxycodone)	☐ Yes ☐ No If yes, would you like to try other pain management alternatives? ☐ Yes ☐ No
Do you have any allergies? (Medication, Food, Animal, Other)	☐ Yes ☐ No Allergy: ______________ Reaction: ______________ Allergy: ______________ Reaction: ______________
Please list your Medications (include dose strength and frequency).	1. ______________ 2. ______________ 3. ______________ 4. ______________ 5. ______________ 6. ______________
How do you rate your oral health? (teeth, gums, dentures)	☐ Excellent ☐ Good ☐ Fair ☐ Poor
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 Cancer Type: ___________________ ☐ Cardiac Arrythmias	☐ COPD ☐ Coronary Artery Disease ☐ Depression ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ High Cholesterol ☐ Statin Therapy (simvastatin, rosuvastatin, atorvastatin) ☐ Gallbladder Disease ☐ GERD (Acid Reflex) ☐ 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 ☐ Other: ___________________

Past Surgeries/Recent Hospitalizations *(include emergency room and urgent care visits)*

Tobacco/Vaping Use Screening

Have you ever used tobacco?	☐ Yes ☐ No
Have you used tobacco in the last 30 days?	☐ Yes ☐ No
What type of tobacco have you used?	☐ Cigarettes/Cigars ☐ Pipe ☐ Chew ☐ Smokeless ☐ Snuff
Have you ever tried to quit using tobacco?	☐ Yes ☐ No
Do you vape?	☐ Yes ☐ No If yes, what device? _____________________________ How often? ___________________
Have you ever had passive smoke or vaping exposure?	☐ Yes ☐ No

Alcohol Screening/Caffeine Use

Do you drink alcohol?	☐ Yes ☐ No ☐ Former Quit Date: ___________________

What type of alcohol?	☐ Beer & Liquor ☐ Beer & Wine ☐ Beer ☐ Hard Liquor ☐ Wine ☐ Other: ________________
Frequency?	☐ Daily ☐ Occasionally ☐ Rarely ☐ Socially ☐ Other
Amount?	☐ ____ beer(s) ☐ ____ glass(es) ☐ ____ pack(s) ☐ ____ pints/bottles
How many times in the past year, have you had 4 or more drinks in a day?	☐ None ☐ 1-2 ☐ 3-5 ☐ > 5
Have you ever felt the need to cut down on drinking?	☐ Yes ☐ No
Ever felt annoyed by criticism of drinking?	☐ Yes ☐ No
Had guilt feelings about drinking?	☐ Yes ☐ No
Ever taken morning eye opener?	☐ Yes ☐ No
Do you drink/consume caffeine	☐ Yes ☐ No
What type of caffeine do you consume?	☐ Chocolate ☐ Coffee ☐ Energy Drinks ☐ Soda ☐ Tablets ☐ Tea
Physical Activity and Lifestyle	
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: ________________________ ☐ I don't exercise
How often do you exercise?	☐ Daily ☐ 2-3x/week ☐ 4-5x/week ☐ Never
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 If yes, number of falls: ______
Have you had an injury from a fall in the last year?	☐ Yes ☐ No

Gender & Sexual History	
What is your sexual orientation?	☐ Heterosexual (straight) ☐ Homosexual (gay, lesbian) ☐ Bisexual ☐ I don't' know ☐ Other: ______________
What is your current gender identity?	☐ Male ☐ Female ☐ Male to Female Transgender (Trans Female) ☐ Female to Male Transgender (Trans Male) ☐ Genderqueer (neither exclusively male or female) ☐ Additional or Other: ________________ ☐ I choose not to disclose
Are you Sexually Active?	☐ Yes ☐ No
How many current sexual partners do you have?	☐ 0-1 ☐ 2-4 ☐ 5+
How many lifetime sexual partners do you have?	☐ 0-1 ☐ 2-4 ☐ 5+
Do you practice safe sex?	☐ Yes ☐ No

Your Family's Medical History *(list the conditions your family has/had)*	
☐ Unknown/Adopted ☐ No relevant family history	☐ Alzheimer's or Dementia ☐ Asthma ☐ Cancer type: ________________ ☐ Cardiovascular Disease ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Other Please explain: ________________ ☐ Storke

Psychosocial Health (Depression Screening) Over the past 2 weeks, how often have you been bothered by any of the following?	
Little interest or pleasure in doing things?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday

Feeling down, depressed, or hopeless?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Trouble Falling or staying asleep, or sleeping too much	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Feeling tired or having little energy?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Poor appetite or overeating?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Feeling bad about yourself- or that you are a failure or have let yourself or you family down?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Trouble concentrating on things, such as reading the newspaper or watching television?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Moving or speaking so slow 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?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday

Thoughts that you would be better off dead, or of hurting yourself in some way?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Domestic Violence Screening	
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
Women: Cervical Cancer Screening *(ages 18+ years)*	
Have you had a pap smear and/or HPV test in the past 3 years?	☐ Yes ☐ No ☐ Not sure Date: ____________________ Location: ________________________________
Colorectal Cancer Screening *(all patients, ages 45+ 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: ____________________ Location: ________________________________
Have you had a colonoscopy in the last 10 years?	☐ Yes ☐ No ☐ Not sure Date: ____________________ Location: ________________________________
Women: Breast Cancer Screening *(ages 40+)*	
Have you had a mammogram within the last year?	☐ Yes ☐ No ☐ Not sure Date: ____________________ Location: ________________________________
Men: Prostate Cancer Screening *(ages 45+)*	
Have you ever had a prostate specific antigen (PSA) blood test or digital rectal exam?	☐ Yes ☐ No ☐ Not sure Date: ____________________ Location: ________________________________