Patient's Name_____ DOB_____

HEALTH RISK ASSESSMENT

Medicare Patients Only

Society History

Physical Activity: In past 7 days, how many days did you exercise? ____ days _____ minutes/day

How Intense was your typical exercise?

- ☐ None (currently not exercising)
- ☐ Light (stretching or slow walking)
- ☐ Moderate (brisk walking)
- ☐ Heavy (Jogging or swimming)
- ☐ Very Heavy (fast running or stair climbing)

Alcohol/Tobacco Use: In the past 7 days how many days did you drink alcohol? ____days

On days when you drank alcohol, how often did you have (5 or more for men/4 or more for women) drinks in one occasion?

- ☐ Never
- ☐ Once during the week
- ☐ 2-3 times during
- ☐ More than 3 times during the week

Did you ever drive after drinking, or ride with a driver who had been drinking? ☐ Yes ☐ No

Do you always fasten your seat belt when you are in a car? ☐ Yes ☐ No

In the last 30 days, have you used tobacco? Smoked ☐ Yes ☐ No Smokeless ☐ Yes ☐ No

If yes to either, would you be interested in quitting tobacco use within the next month? ☐ Yes ☐ No

Mental Health

Depression: In the past 2 weeks, how often have you felt down, depressed, or hopeless?

- ☐ Almost never
- ☐ Some of the time
- ☐ Most of the time
- ☐ Almost all of the time

In the past 2 weeks, how often have you felt little interest or pleasure in doing things?

- ☐ Almost never
- ☐ Some of the time
- ☐ Most of the time
- ☐ Almost all of the time

Have your feelings caused you distress or interfered with you ability to get along socially with friends or family?

☐ Yes ☐ No

Anxiety: In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

- ☐ Almost never
- ☐ Some of the time
- ☐ Most of the time
- ☐ Almost all of the time

In the past 2 weeks, how often were you not able to stop worrying or control your worrying?

- ☐ Almost never
- ☐ Some of the time
- ☐ Most of the time
- ☐ Almost all of the time

Patient's Name_____ DOB_____

High Stress: How often is stress a problem for you in handling such things as (circle one):

1.	Your health	Never/Rarely	Sometimes	Often	Always
2.	Your finances	Never/Rarely	Sometimes	Often	Always
3.	Your family/social relationship:	Never/Rarely	Sometimes	Often	Always
4.	Your work:	Never/Rarely	Sometimes	Often	Always

Social/Emotional Support: How often do you get the social and emotional support you need?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Usually
- ☐ Always

General Health

In general, would you say your health is:

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very Good
- ☐ Excellent

How would you describe the condition of your mouth and teeth -- including false teeth or dentures?

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very Good
- ☐ Excellent

In the past 7 days, how much general pain have you felt?

- ☐ None
- ☐ Some
- ☐ A lot

Nutrition: In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = cup of vegetables, ½ cup of cooked vegetables, 1 medium piece of fruit, 1 cup + size of a baseball).

____ servings/day

In the past 7 days, how many servings of high fiber or whole grain foods did yoy typically eat each day? (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole grain or high fiber cereal, ½ cup of oatmeal, ½ cup of brown rice or whole wheat pasta.)

____ servings/day

In the past 7 days, how many servings of fried or high fat foods did you typically eat each day? (Potato chips, bacon, donuts, creamy salad dressings, whole milk or cheese, anything fried, mayonnaise.

____ servings/day

In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?

____ sugar sweetened beverages consumed per day

Patient's Name_____ DOB_____

Activities of Daily Living

In the past 7 days did you need help from others to perform everyday activities such as:

Activity	Yes	No
Eating		
Dressing		
Grooming		
Bathing		
Walking		
Using Toilet		

In the past 7 days did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications? ____Yes ____No

Sleep: Each night, how many hours of sleep do you usually get? ____ hours

Do you snore or has anyone told you that you snore? ____Yes ____No

In the past 7 days, how often have you felt sleepy during the daytime?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Usually
- ☐ Always

Biometric measures

Blood pressure: If your blood pressure was checked within the past year, what was it when it was last checked?

- ☐ Low or normal (at or below 120/80)
- ☐ Borderline high (120/80 to 139/89)
- ☐ High (140/90 or higher)
- ☐ Don't know/not sure

Cholesterol: If your cholesterol was checked within the past year, what was your total cholesterol when it was last checked?

- ☐ Desirable (below 200)
- ☐ Borderline High (200-239)
- ☐ High (240 or higher)
- ☐ Don't know/not sure

Blood Glucose: If your glucose was check, what was your fasting blood glucose (blood sugar) level the last time it was checked?

- ☐ Desirable (below 100)
- ☐ Borderline High (100=125)
- ☐ High (126 or higher)
- ☐ Don't know/not sure

If diabetic, and if you have had your hemoglobin A1C level check within the past eyar, what was it the last time you had it checked?

- ☐ Desirable (6 or lower)
- ☐ Borderline high (7)
- ☐ High (8 or higher)
- ☐ Don't know/not sure

Mental Health Questionare

Patient Name: _____ **DOB:** _____

Date of Assessment: _____

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

Circle the appropriate column	Little or none of the time	Some of the time	Good part of the time	Most or all of the time
• I feel down-hearted and blue	1	2	3	4
• Morning is when I feel the best	4	3	2	1
• I have crying spells or feel like crying	1	2	3	4
• I have trouble sleeping at night	1	2	3	4
• I eat as much as I used to	4	3	2	1
• I still enjoy sex	4	3	2	1
• I notice that I am losing weight	1	2	3	4
• I have trouble with constipation	1	2	3	4
• My heart beats faster than usual	1	2	3	4
• I get tired for no reason	1	2	3	4
• My mind is as clear as it used to be	4	3	2	1
• I find it easy to do the things I used to	4	3	2	1
• I am restless and can't keep still	1	2	3	4
• I feel hopeful about the future	4	3	2	1
• I am more irritable than usual	1	2	3	4
• I find it easy to make decisions	4	3	2	1
• I feel that I am useful and needed	4	3	2	1
• My life is pretty full	4	3	2	1
• I feel that others would be better off if I were dead	1	2	3	4
• I still enjoy the things I used to do	4	3	2	1

Total= _____