Health Risk Assessment

Name: _____ DOB: _____ Date: _____

1. Do you smoke? **Never** ☐ **Former** ☐ **Current** ☐
2. Do you drink alcohol? **No** ☐ **Yes** ☐
3. In the past year, have you used street drugs or medications not prescribed to you? **No** ☐ **Yes** ☐
4. Have you fallen 2 or more times in the past year? **No** ☐ **Yes** ☐
5. Have you had a fall with an injury in the past year? **No** ☐ **Yes** ☐
6. Do you have serious difficulty hearing? **No** ☐ **Yes** ☐
7. Have you noticed any changes in your memory lately? **No** ☐ **Yes** ☐
8. In the past 2 weeks, have you had little interest or pleasure in doing things? **No** ☐ **Yes** ☐
9. In the past 2 weeks have you felt down, depressed or hopeless? **No** ☐ **Yes** ☐
10. In the past 2 weeks, have you felt nervous, anxious or on edge? **No** ☐ **Yes** ☐
11. In the past 2 weeks, were you not able to stop worrying or control your worrying? **No** ☐ **Yes** ☐
12. In general, would you say your health is… **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor** ☐
13. How many days a week do you do physical activity such as swimming, walking, yoga, ect? _____ **Days a week**
    Of those days, how many minutes are you active? _____ **Minutes**
14. Do you worry whether your food will run out before you have money to buy more? **No** ☐ **Yes** ☐
15. How often do you feel lonely or isolated from those around you? **Rarely** ☐ **Sometimes** ☐ **Often** ☐ **Always** ☐
16. In the past 7 days, did you need help from other to perform everyday activities such as, eating, getting dressed, bathing, walking or using the toilet? **No** ☐ **Yes** ☐
17. In the past 7 days, did you need help from others to take care of such things like laundry, housework, banking, shopping, food preparation, transportation or taking your own medicine? **No** ☐ **Yes** ☐

Please check any of the following that you have experienced recently:

Constitutional
- ☐ Fever/chills
- ☐ Night sweats
- ☐ Unexplained weight gain
- ☐ Unexplained weight loss
- ☐ Fatigue/feeling tired

Eyes
- ☐ (circle)painful, red, watery, dry
- ☐ Change or loss of vision
- ☐ Eye disease/injury

Ears, Nose, Throat
- ☐ Loss or change in hearing
- ☐ Ear pain or discharge(circle)
- ☐ Frequent nosebleeds
- ☐ Frequent stuffy nose/sinuses
- ☐ Sore throat/dry mouth
- ☐ Painful teeth/bleeding gums
- ☐ Mouth ulcers
- ☐ Ringing in ears

Cardiovascular
- ☐ Chest pain with exerting yourself or even at rest
- ☐ Arm pain on exertion
- ☐ Shortness of breath when walking
- ☐ Shortness of breath when lying down
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Light-headed on standing
- ☐ Frequent ankle swelling

Respiratory
- ☐ Frequent cough
- ☐ Frequent wheezing
- ☐ Frequently short of breath
- ☐ Cough up blood
- ☐ Loud snoring, gasping or stop breathing while asleep

Gastrointestinal
- ☐ Abdomen or stomach pains
- ☐ Frequent nausea / vomiting
- ☐ Frequent constipation
- ☐ Change in appetite
- ☐ Frequent diarrhea
- ☐ Red blood in stools or black, tar-like stools
- ☐ Frequent diarrhea
- ☐ Vomiting blood
- ☐ Indigestion/fullness
- ☐ Frequent heartburn or reflux

Genitourinary
- ☐ Loss of control of urination
- ☐ Difficulty urinating
- ☐ Frequent urge to urinate
- ☐ Blood in urine
- ☐ Incomplete emptying

Women
- ☐ Unusual discharge from vagina
- ☐ Pain with sex
- ☐ Monthly periods: (circle)

Regular / Not regular / Painful / Absent Heavy / > 5 days / Spotting
- ☐ Date of most recent period: ___/___/___

Men
- ☐ Discharge from penis
- ☐ Erections painful or difficult
- ☐ Lump in testicles/scrotum

Musculoskeletal
- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Joints often painful: (circle)

Shoulder / Elbow / Wrist / Hand
Hip / Knee / Ankle
- ☐ Frequent/daily back pain
- ☐ Swelling in extremities
- ☐ Frequent/daily neck pain
- ☐ Difficulty walking
- ☐ Muscle cramps
- ☐ Osteoporosis/fractures

Skin and Breasts
- ☐ Changing/growing mole (location): _____
- ☐ Jaundice
- ☐ Rash (location)_____
- ☐ Cuts: _____
- ☐ Sore that does not heal
- ☐ Change in hair/nails
- ☐ Dry, peeling, cracking skin
- ☐ Change in skin color
- ☐ (circle)Breast pain, lump, or nipple discharge. Left or Right

Neurological
- ☐ Loss of consciousness
- ☐ Weakness in a body part
- ☐ Frequent numbness/tingling in a body part
- ☐ Seizures
- ☐ Dizziness
- ☐ Frequent headaches/migraines
- ☐ Tremors
- ☐ Change in walking pattern
- ☐ Loss of feeling

Endocrine
- ☐ Fatigue
- ☐ Recent increase in thirst
- ☐ Hair loss or increased hairiness
- ☐ Not able to tolerate heat or cold

Hematologic/Lymphatic
- ☐ Enlarged or painful glands: (circle) neck / armpit / groin
- ☐ Easy bruising / bleeding (circle)
- ☐ Anemia
- ☐ Frequent nosebleeds

Allergic/Immunologic
- ☐ Runny nose
- ☐ Frequent ear/sinus/chest infection
- ☐ Frequent itching or hives
- ☐ Frequent sneezing
- ☐ Sensitivity to foods, pets, etc.
- ☐ Exposed to HIV/AIDS, Tuberculosis, hepatitis BorC

PHQ9 & GAD7 **Patient Name:**

Over the last 2 weeks, On how many days have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly everyday**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- Or that you are a failure or have let you or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly 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	0	1	2	3
9.Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total:				
If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not at all Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult

Over the last 2 weeks , On how many days have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly everyday**
1.Feeling Nervous, anxious or on edge	0	1	2	3
2. Not being able to control or stop worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total:				
If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not at all Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult