Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions.

Direction of Feed

Health Risk Assessment

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY***.

PLEASE PRINT PATIENT'S LAST NAME

Marking Instructions

Please use a #2 pencil. Fill in the complete oval as shown...

FIRST NAME

DATE OF BIRTH

Month Day Year

How would you rate your overall health? (Please select one.)

poor good fair excellent

What health conditions do you currently have? (Please mark each condition that applies to you.)

- heart disease
- breathing problems caused by emphysema or asthma
- diabetes or other blood sugar problems
- other conditions
- heart failure or an enlarged heart
- kidney dialysis
- depression
- **NONE**

please fold on dotted line

How many different prescriptions do you take each day?

0 1-3 4-6 7-10 11 or more

Do you have any trouble getting around at home or outside your home?	yes	no
Do you need the help of another person to move around inside or outside your home?	yes	no
Do you live alone?	yes	no
Do you need to stay in the house most or all of the time?	yes	no

Do you need help at home due to your health problems?	yes	no
Has it been hard for you to get the help you need?	yes	no

In the previous 12 months, have you stayed overnight as a patient in the hospital?	yes	no

About how many times? 1 time 2-3 times 4 or more times

In the previous month, have you gone to an urgent care or emergency room?	yes	no

please fold on dotted line

Over the <u>past two weeks</u> how often have you been <u>bothered by</u> the following problems?

	Not at all	Several days	More than half of the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				

Do you have difficulty getting to doctor's appointments or other medical services? yes no

Direction of Feed

Health Risk Assessment

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY***.

Have you had any problems with balance or walking? ◯ yes ◯ no

Are you physically active? (e.g., walking, group classes, stationary bike, etc.) ◯ yes ◯ no

Have you fallen (without having been pushed) **in the last 3 months?** ◯ yes ◯ no

Do you use any of the following to get around? (Select all that apply.)

◯ cane ◯ prosthetic device
◯ walker ◯ power operated vehicle (scooter)
◯ wheelchair ◯ **NONE**

What is your smoking status? ◯ current (every day) ◯ current (some days) ◯ previous ◯ never

How many packs per day do you (or did you) **smoke?** ◯ less than 1 ◯ 1-2 ◯ more than 2

How many years have you (or did you) **smoke?** ◯ less than 5 ◯ 5 ◯ 10 ◯ 15 ◯ 20 ◯ 25 ◯ 30 ◯ 35 ◯ 40+

Have you had a flu shot in the last 12 months? ◯ yes ◯ no

please fold on dotted line

Any recent vision changes? ◯ yes ◯ no

Any recent hearing changes? ◯ yes ◯ no

Have you had problems with urine leakage? ◯ yes ◯ no

Have you had any problems with your short-term memory? (e.g., What did you have for dinner last night?) ◯ yes ◯ no

Have you had any problems with your long-term memory? (e.g., Where were you born?) ◯ yes ◯ no

Do you have trouble understanding instructions? ◯ yes ◯ no

If you have pain, on a scale of 1-10, what is your normal pain level?

(0 = no pain, 10 = the most pain you have felt)

☺ ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ☹

Do you have any trouble completing the following activities?

please fold on dotted line

	No Trouble	Need Some Help	Need Help
Bathing	◯	◯	◯
Getting dressed	◯	◯	◯
Getting to and from the toilet	◯	◯	◯
Shopping	◯	◯	◯
Preparing meals	◯	◯	◯
Feeding yourself	◯	◯	◯
Using the telephone	◯	◯	◯
Housekeeping	◯	◯	◯
Laundry	◯	◯	◯
Managing medications	◯	◯	◯
Managing household finances	◯	◯	◯