<NAME OF PRACTICE>
<ADDRESS>
<PHONE/FAX>

Date _____ Patient Name _____ Date of Birth _____

HEALTH RISK ASSESSMENT

PHYSICAL ACTIVITY

Do you exercise? ☐ Yes ☐ No

If you exercise:

In the past 7 days, how many days did you exercise? _____ How long did you exercise (minutes per day)? _____

How intense was your typical exercise?

☐ Light (like stretching or slow walking) ☐ Moderate (like brisk walking)

☐ Heavy (like jogging or swimming) ☐ Very heavy (like fast running or stair climbing)

TOBACCO/ALCOHOL/DRUG INFORMATION

TOBACCO USE

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

If yes:

Smoked: ☐ Yes ☐ No If yes, amount/frequency?_____

Used a smokeless tobacco product: ☐ Yes ☐ No If yes, amount/frequency?_____

Would you be interested in quitting tobacco use within the next month? ☐ Yes ☐ No

ALCOHOL & DRUG USE

Do you drink alcohol? ☐ Yes ☐ No If yes:

How many drinks per week? _____ Do you drink more than 4 drinks on one occasion? ☐ Yes ☐ No

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

Have you ever used recreational/street drugs? ☐ Yes ☐ No If yes, date/amount/frequency?_____

Have you ever misused prescription drugs? ☐ Yes ☐ No If yes, date/amount/frequency?_____

Has drinking or drugs ever caused problems in any of the following areas:

☐ family ☐ employment ☐ legal ☐ emotional ☐ social ☐ financial ☐ behavioral ☐ physical

Does a relative, loved one, friend, court or employer think so? ☐ Yes ☐ No

OTHER

Do you always wear your seat belt? ☐ Yes ☐ No Women: Are you pregnant? ☐ Yes ☐ No

What is your employment status? ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Disabled

Highest level of education: ☐ College ☐ High School ☐ GED ☐ Other: please specify_____

PAIN In the past 7 days, how much pain have you felt? ☐ None ☐ Some ☐ A lot

GENERAL HEALTH

In general, would you say your health is: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

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

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

SOCIAL

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Is either parent deceased? ☐ Father ☐ Mother

Do you feel safe at home? ☐ Yes ☐ No Do you want to discuss abuse? ☐ Yes ☐ No Is someone threatening you? ☐ Yes ☐ No

Are there any significant issues affecting family/significant other? ☐ Yes ☐ No If yes, please explain: _____

_____

ANXIETY In the past 2 weeks, how often have you felt:

Nervous, anxious, or on edge? ☐ Almost all of the time ☐ Most of the time ☐ Some of the time ☐ Almost never

Unable to stop worrying or control your worrying?

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

Date _____ Patient Name _____ Date of Birth _____

DEPRESSION

In the past 2 weeks, how often have you felt:

Down, depressed, or hopeless? ☐ Almost all of the time ☐ Most of the time ☐ Some of the time ☐ Almost never

Little interest or pleasure in doing things? ☐ Almost all of the time ☐ Most of the time ☐ Some of the time ☐ Almost never

Have your feelings caused you distress or interfered with your ability to get along socially with family or friends? ☐ Yes ☐ No

Have you ever thought about or attempted suicide? ☐ Yes ☐ No If yes, when and by what means? _____

_____

HIGH STRESS

How often is stress a problem for you in handling your health, finances, family or social relationships, and work?

☐ Never or rarely ☐ Sometimes ☐ Often ☐ Always

SOCIAL/EMOTIONAL SUPPORT

How often do you get the social and emotional support you need? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

NUTRITION

Consider the past 7 days: How many servings did you typically eat each day of the following foods?

FRUITS AND VEGETABLES Servings per day_____

(1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.)

HIGH FIBER OR WHOLE GRAIN FOODS Servings per day_____

(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)

FRIED OR HIGH-FAT FOODS Servings per day_____

(e.g., fried foods, bacon, chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, or cheese)

SUGAR-SWEETENED (NOT DIET) BEVERAGES Sugar sweetened beverages consumed per day (in ounces) _____

ACTIVITIES OF DAILY LIVING

Do you regularly need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet? ☐ Yes ☐ No

SLEEP

How many hours of sleep do you usually get each night? _____ hours

Do you snore or has anyone told you that you snore? ☐ Yes ☐ No

How often do you feel sleepy during the daytime? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

BIOMETRIC MEASURES — Completed by Patient ONLY

BLOOD PRESSURE

When did you last check your blood pressure? _____ and what was it?

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

CHOLESTEROL

When was your cholesterol last checked?_____ and what was it?

☐ Desirable (< 200) ☐ Borderline high (200-239) ☐ High (>=240) ☐ Don't know/not sure

BLOOD GLUCOSE

When did you last check your fasting blood glucose (blood sugar) level? _____ and what was it?

☐ Desirable (< 100) ☐ Borderline high (100-125) ☐ High (>=126) ☐ Don't know/not sure

HEMOGLOBIN A1C

If you are diabetic, when did you last have your hemoglobin A1c level checked?_____ and what was it?

☐ Desirable (<=6) ☐ Borderline high (7) ☐ High (>=8) ☐ Don't know/not sure

OVERWEIGHT/OBESITY

Height without shoes: Feet_____Inches_____ Weight: _____ pounds