

Health Risk Assessment

Please complete the entire questionnaire completely so that your provider has complete and up to date information about you. Bring this with you to your appointment along with a list of your current medications*.

**Medications - Please bring a list of ALL your medication to this visit including all vitamins, supplements or over-the-counter medications.*

Name	Date of Birth	Today's Date

Medical History	Answer
Have there been any updates to your medical history in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
If yes , what has changed?	
Have you seen any Medical Providers outside of the Trinity Health/IHA health system in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
If yes , please provide Provider Name and Reason for visit	
Provider Name(s)	Reason
Provider Name(s)	Reason
Any Hospitalizations outside of Trinity Health in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Hospital Name(s)	Reason

General Health	Answer
How would you describe your typical physical function or exercise?	<input type="checkbox"/> Very heavy (such as fast running or stair climbing) <input type="checkbox"/> Heavy (such as jogging or swimming) <input type="checkbox"/> Moderate (such as brisk walking) <input type="checkbox"/> Light (such as stretching or slow walking) <input type="checkbox"/> I am not currently exercising.
In the last 7 days, did you have difficulty performing the following self-care activities?	
Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grooming	<input type="checkbox"/> Yes <input type="checkbox"/> No
Getting dressed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Walking/Ambulating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Using the toilet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shopping	<input type="checkbox"/> Yes <input type="checkbox"/> No	Preparing food	<input type="checkbox"/> Yes <input type="checkbox"/> No
Housekeeping	<input type="checkbox"/> Yes <input type="checkbox"/> No	Doing laundry	<input type="checkbox"/> Yes <input type="checkbox"/> No
Handling finances	<input type="checkbox"/> Yes <input type="checkbox"/> No	Going places/Transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Using the telephone	<input type="checkbox"/> Yes <input type="checkbox"/> No	Managing medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any specific concerns performing any of these activities?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Considering the last two weeks, how would you respond to the following questions?			
In general, how would you describe your health?			
<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
How would you describe your overall life satisfaction?			
<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Have you had increased stress?			
<input type="checkbox"/> Nearly daily	<input type="checkbox"/> More than half the days	<input type="checkbox"/> A couple of days	<input type="checkbox"/> Not at all
Have you had increased anger?			
<input type="checkbox"/> Nearly daily	<input type="checkbox"/> More than half the days	<input type="checkbox"/> A couple of days	<input type="checkbox"/> Not at all
Have you felt social isolation or loneliness?			
<input type="checkbox"/> Nearly daily	<input type="checkbox"/> More than half the days	<input type="checkbox"/> A couple of days	<input type="checkbox"/> Not at all
Have you had more pain than usual?			
<input type="checkbox"/> Nearly daily	<input type="checkbox"/> More than half the days	<input type="checkbox"/> A couple of days	<input type="checkbox"/> Not at all
Have you experienced unusual fatigue?			
<input type="checkbox"/> Nearly every day	<input type="checkbox"/> More than half the days	<input type="checkbox"/> A couple of days	<input type="checkbox"/> Not at all
Have you felt down, depressed, or hopeless?			
<input type="checkbox"/> Nearly every day	<input type="checkbox"/> More than half the days	<input type="checkbox"/> Several days	<input type="checkbox"/> Not at all
Have little interest or pleasure in doing things?			
<input type="checkbox"/> Nearly every day	<input type="checkbox"/> More than half the days	<input type="checkbox"/> Several days	<input type="checkbox"/> Not at all

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Generally, how would you describe your diet?

<input type="checkbox"/> Healthy	<input type="checkbox"/> Standard	<input type="checkbox"/> Plant-based	<input type="checkbox"/> Poor
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Special, please describe:

Illegal or Recreational Drugs

In the past year, how often have you used Illegal Drugs or Recreational Drugs?

<input type="checkbox"/> Nearly every day	<input type="checkbox"/> More than half the days	<input type="checkbox"/> A couple of days	<input type="checkbox"/> Not at all
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If yes, are you interested in interventional resources?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
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Additional Questions:

Do you have any teeth issues or dental problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you have any concerns about sexual activity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you use your seatbelt in a vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you feel unsteady when standing or walking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Have you experienced a fall in the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you feel safe within your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you have the following home Safety Detectors:	Smoke:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Carbon Monoxide:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Has a first-degree relative been diagnosed with any of the following? (mother, father, siblings, children)	Cancer:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If unknown, why?	

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<p>Do you have an Advanced Directive in place? Advanced Directives (Durable Power of Attorney for Healthcare) are documents that can help ensure your wishes are followed in the instance you cannot make your own medical decisions.</p> <p>If yes, please bring a copy with you so that we can add it to your record.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
<p>If no, would you like some information?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

OFFICE USE ONLY PROVIDER SIGNATURE	DATE
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