Health Risk Assessment (HRA)

Name: _____ **Date:**_____

Date of Birth: _____ **Preferred language:**_____

Form completed by: □ Self □ Friend/family □ Office staff □ Other _____

How do you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Are there any changes in your medical history since last year? ☐ Yes ☐ No (if yes, list)

On how many days during the week do you…? (Circle the appropriate answer below)

1) Do physical activity (e.g. walking, sports, etc.) for at least 30 minutes?	0	1 - 2	3 - 4	≥5
2) Include strength exercises (weights or bands) in your physical activity routine?	0	1 - 2	3 - 4	>5
3) Eat 5 or more servings of fruits and vegetables (one serving equals ½ cup)?	0	1 - 2	3 - 4	≥5
4) Eat 5 or more servings of grains (one serving equals one slice of bread, ½ cup of cereal, etc.)?	0	1 - 2	3 - 4	>5
5) Eat 2 or more servings of dairy products (milk, yogurt or cheese)?	0	1 - 2	3 - 4	≥5
6) Eat fast food?	0	1 - 2	3 - 4	≥5
7) Cut the size of your meals or skip meals because you don't have enough food (not enough money or enough help to shop or cook)?	0	1 - 2	3 - 4	>5
8) Have more than one drink of alcohol (beer, liquor, wine) per day?	0	1 - 2	3 - 4	≥5
9) Get at least 7 hours of sleep?	0	1 - 2	3 - 4	≥5
10) Use tobacco or nicotine products (cigarettes, e-cigarettes, smokeless tobacco, cigars, or pipes) or are close to others who do?	0	1 - 2	3 - 4	>5
11) Leave your home to run errands, go to work, go to meetings, classes, church, social functions, etc. (not counting doctor's visits)?	0	1 - 2	3 - 4	>5
12) Have physical pain that affects your activities?	0	1 - 2	3 - 4	≥5

13) Do you have mouth or tooth problems that make it difficult to eat? ☐ Yes ☐ No

14) Do you have enough money to pay for your medicines, medical supplies, and medical care? ☐ Yes ☐ No

15) About how many times **in the last month** have you…

…missed taking your medicines? _____times

…taken your medicines differently than prescribed by your doctor? _____times

…taken any over-the-counter medicines (non-prescription medicines, supplements or herbal medicines)? _____times

16) Do you drive? ☐ Yes ☐ No

If no, are you able to get where you need to go? ☐ Yes ☐ No

17) Are you sexually active? (if yes, # partners in last 12 months) ☐ Yes ☐ No

18) Do you have problems hearing or seeing? (if yes, circle which one) ☐ Yes ☐ No

19) In the **past 12 months**, have you had any problem with balance or walking, or have you had any falls? If yes to falls, how many falls? _____ ☐ Yes ☐ No

Are you concerned about falling? ☐ Yes ☐ No

20) Are you or your family concerned about your memory? ☐ Yes ☐ No

21) In the **past 6 months**, have you had a problem with leakage of urine? ☐ Yes ☐ No

22) In the **past month**, have you needed help managing your finances? ☐ Yes ☐ No

23) Do you think anybody is taking or using your money without your permission? ☐ Yes ☐ No

24) In the **past 7 days**, have you needed help from others…

….to eat, bathe, get dressed or use the toilet? ☐ Yes ☐ No

….to do laundry, cooking, housekeeping or shopping? ☐ Yes ☐ No

….to take your medicines? ☐ Yes ☐ No

25) Do you or your caregiver have enough help/support for caregiving duties? (skip if you do not give or receive care) ☐ Yes ☐ No

26) Are you often lonely? ☐ Yes ☐ No

27) Do you have family and friends who care about you and you can count on for help when you need something or have a problem? ☐ Yes ☐ No

28) Is anybody hurting (hitting or yelling) or not taking care of you? ☐ Yes ☐ No

29) Do you have an Advance Directive or Living Will? ☐ Yes ☐ No

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

	Not at all	Several Days	> Half of the Days	Nearly Every Day
33) Anxiety or stress about your health, money, family, friends or work?	☐	☐	☐	☐
34) Little interest or pleasure in doing things?	☐	☐	☐	☐
35) Feeling down, depressed or hopeless?	☐	☐	☐	☐

List of Medicines and Supplements You Take

Name of medicine/supplement	Dose and how often taken
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	

Other healthcare providers you see (and their specialty)	
1.	5.
2.	6.
3.	7.
4.	8.

Medical supplies you receive (e.g. oxygen) and who supplies it: