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Health Risk Assessment Form

Name & Demographic Information

Name:	Today's Date:
Street Address:	City:
State:	Zip Code:

Gender: ❑ Male ❑ Female | Race: ❑ Asian ❑ Black or African American ❑ Hispanic or Latino ❑ White ❑ Mixed Race

Date of Birth: Height: ft. in.

Weight: lbs.

Personal Health Status

In the past year, my health has:
- ❑ Improved
- ❑ Declined
- ❑ Stayed the same

Comments:

I have been previously diagnosed with:
- ❑ Heart disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Diabetes
- ❑ Pre-diabetes
- ❑ Stroke
- ❑ Cancer

Other:

Past Surgical History:
Type and date:

- ❑ _____ Date_____
- ❑ _____ Date_____
- ❑ _____ Date_____
- ❑ _____ Date_____

Family History

My father, mother, brother, or sister has/had
- ❑ Heart disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Diabetes
- ❑ Pre-diabetes
- ❑ Stroke
- ❑ Cancer

Other:

Social History

Do You smoke: ❑ Yes How Long_____ Packs per day_____ ❑ No or Year quit smoking_____

Alcohol Use: ❑ Never ❑ Daily #drinks per day_____ ❑ Occasional

Illegal Drug Use: ❑ Never ❑ Daily ❑ Occasional describe:_____

Do you live: ❑ Alone ❑ w/family ❑ assisted living ❑ nursing home ❑ other

Please complete all pages and bring to your Medicare Annual Wellness Visit

Name:_____

Personal Safety & Behavior	
Smoke Detectors: ❑ Home has smoke detectors ❑ No smoke detectors	Bathroom: ❑ Bathtub has non-skid surface ❑ No non-skid surface
Do you drives: ❑ Yes ❑ No	Do you wear a seatbelt? ❑ Yes ❑ No ❑ Sometimes
Do you wear sunscreen? ❑ Yes ❑ No ❑ Sometimes	
Mood	
Do you feel depressed or sad: ❑ Yes ❑ No ❑ Sometimes	In the past year has your mood: ❑ improved ❑ declined ❑ stayed the same
Do you feel tired or have little energy: ❑ Yes ❑ No ❑ Sometimes	Do you feel bad about yourself or feel you have let your family down?: ❑ Yes ❑ No ❑ Sometimes
Do you have emotional support from family or friends: ❑ Yes ❑ No ❑ Sometimes	Is stress a problem for you?
Personal Fitness	
How often do you exercise:	Type:
Eating Patterns	
How many meals do you eat daily?	
How often do you snack?	
How many times a week do you eat fast food?	
How many servings of fruits/vegetables do you eat per day?	
Activities of Daily Life	
Do you have difficulty with any of the following: (if yes please describe the difficulty)	
Using telephone: ❑ Yes ❑ No	
Shopping: ❑ Yes ❑ No	
Manage money: ❑ Yes ❑ No	
Manage medications: ❑ Yes ❑ No	
Laundry: ❑ Yes ❑ No	
Food preparation: ❑ Yes ❑ No	
Housekeeping: ❑ Yes ❑ No	
Dressing: ❑ Yes ❑ No	
Bathing: ❑ Yes ❑ No	
Toileting: ❑ Yes ❑ No	
Ability to walk: ❑ Yes ❑ No	
Feeding: ❑ Yes ❑ No	

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