HEALTH RISK ASSESSMENT FORM

Dear Member,

Answering the questions below helps us to find ways to help you continue to feel good and improve your health.

Date	Name First	Last Name	DOB	Male ❑ Female ❑ Non-Binary ❑

Contact Preferences

What language do you prefer to speak?

❑ English ❑Vietnamese ❑ Spanish ❑ Korean ❑ Chinese ❑ Tagalog ❑ Other____________________

Current Health Conditions (*Please mark each condition that applies to you.*)

1. What health conditions do you currently have?

- ❑ Asthma
- ❑ COPD
- ❑ Other breathing or lung conditions
- ❑ heart disease
- ❑ Heart failure
- ❑ High blood pressure
- ❑ kidney disease or kidney failure
- ❑ Diabetes or high blood sugar
- ❑ Cancer
- ❑ HIV or AIDS
- ❑ Behavioral or mental health conditions
- ❑ Alzheimer Dementia
- ❑ Other

General Health Topics

2. In general, would you say your health is:

❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

3. Have you had your flu shot within the past year? ❑ Yes ❑ No

4. Have you had a COVID vaccine this year? ❑ Yes ❑ No

5. When did you last have a pneumonia vaccine?

❑ In the last year ❑ Past 2-4 years

❑ Past 5 years ❑ Last 10 years ❑ Never

6. When did you last have a Tdap (Tetanus, diphtheria, pertussis) vaccine?

❑ In the last year ❑ Past 2-4 years ❑ Past 5 years

❑ Last 10 years ❑ Never

7. Have you had a Shingles (RSV, Shingrix) vaccine? ❑ Yes ❑ No

8. Have you had a colonoscopy within the last 10 years? ❑ Yes ❑ No

9. Have you had a stool test to screen for colon cancer within the last year? ❑ Yes ❑ No

10. Have you fallen in the past month? ❑ Yes ❑ No

11. Have you ever smoked? ❑ Yes ❑ No

If yes on average

How many cigarettes do you smoke per day? ___________

How many years have you smoked? ____________

12. Do you have the ability to ambulate (walk around) to get to and from your doctor's visits?

❑ Yes ❑ No

13. Do you use any medical equipment or medical devices? (i.e. cane, walker, wheelchair, bath chair, toilet seat, commode, diapers, hospital bed, pressure mattress, CPAP machine, oxygen, catheters)

❑ Yes ❑ No What Type? ______________________________________

14. In the past year, how many times have you been to the emergency room?

❑ None ❑ Once ❑ Twice ❑ Three or more

15. In the past year, how many times have you stayed overnight as a patient in the hospital?

❑ None ❑ Once ❑ Twice ❑ Three or more

16. How often do you exercise per week?

❑ >5 days ❑ 4-3 days ❑ 2-1 days ❑ Seldom ❑ Never

17. What is your height______________ What is your weight_________________

18. Without wanting to, I have lost or gained 7 lbs in the last six months? ❑ Yes ❑ No

19. Do you always fasten your seat belt when you are in a car?	❑ Yes	❑ No
20. What medication allergies do you have? ____________________		
21. Do you sometimes forget to take your medications?	❑ Yes	❑ No
22. What medications do you take? __________________________		
23. Do you have any food allergies? If yes, what food allergies do you have? ______________________	❑ Yes	❑ No

24. Over the past month, how often have you been bothered by the following:	Not at all	Several days	Daily
Poor appetite or eating too much	❑	❑	❑
Body pain that makes it difficult towork or complete activities	❑	❑	❑

25. Did you ever drink Alcohol?	❑ Yes	❑ No	
26. How much Alcohol do you drink in a day? Drink = 12oz beer 5oz wine Liquor (one shot)		❑ 1-2	❑3 or more

Behavioral Health

27. Over the past month, how often have you been bothered by the following:	Not at all	Several days	Daily
Feeling down, depressed, or hopeless	❑	❑	❑
Trouble falling asleep or sleeping too much	❑	❑	❑
Little interest or pleasure in doing things	❑ Yes	❑ No	
Do you or your family / friends			

have concerns about your memory? ❑ Yes ❑ No

Activities of daily living

28. Do you: ❑ Snore ❑ Have you been told by family or friends you stop breathing while sleeping

29. In the past 7 days, how often have you felt sleepy during the daytime?
❑ Always ❑ Usually ❑ Sometimes ❑ Rarely ❑ Never

At night do you: ❑ Have frequent awakenings ❑ Wake up to go to the bathroom

30. Do you Live in: ❑ An independent house, apartment, condo, or mobile home
❑ An assisted living apartment or board and care home

31. Who do you live with? ___________________________________

32. Is there a friend, relative, or neighbor who would takes care of you? ❑ Yes ❑ No

Name: _________________________Phone: ____________

33. Do you have transportation to and from your doctors' appointments? ❑ Yes ❑ No

Functional Assessment

34. How often do you need help with the following:	Never	Rarely	Sometimes	Always
Continence	❑	❑	❑	❑
Getting around your home	❑	❑	❑	❑
Feeding yourself	❑	❑	❑	❑
Getting in or out of bed or a chair	❑	❑	❑	❑
Caring for yourself, including bathing	❑	❑	❑	❑
Dressing yourself	❑	❑	❑	❑
Using the toilet	❑	❑	❑	❑

Wellness Topics

35. What is the current year? ☐☐☐☐ What month is this? ☐☐☐☐☐☐☐☐☐☐
36. Overall, how willing are you to make changes to improve your health? ❑ Very willing ❑ Somewhat willing ❑ Not currently willing
37. What is your email address?

Optional		
38. Do you have an advance directive?	❑ Yes	❑ No
39. Do you have a POLST – Physician Orders for Life Sustaining Treatment?	❑ Yes	❑ No

Thank you for completing these important health questions.