Health Risk Assessment 2024

Member Name _____ Date of Birth _____

Physician Name _____ Chart # _____

Today's Date _____

Personal Medical History

		Year			Year			Year
☐	High Blood Pressure		☐	Congestive Heart Failure		☐	Asthma	
☐	High Blood Sugar		☐	Heart Attack		☐	Diabetes	
☐	High Cholesterol		☐	Stroke		☐	Thyroid Problem	
			☐	Cancer		☐		

General Health

	Never / Almost Never	Occasionally	Often	Very Often	Always/ Almost Always
I avoid the use of tobacco products (cigarettes, smokeless tobacco, cigars, and pipes) and/or limit myself to 5 drinks (beer, wine, liquor) per week.					
I protect my skin from sun damage by using sunscreen, wearing hats, and/or avoiding tanning booths and sunlamps.					
I visit my dentist every 6 months for regular checkups.					
I see my physician for routine check-ups, health screenings, immunizations, vaccinations and disease prevention.					
I am living a healthy lifestyle.					

Mental Wellness

In the past 2 weeks, how often have you been bothered by the following:

	Never / Almost Never	Occasionally	Often	Very Often	Always/ Almost Always
I am stressed over health, finances, relationships, or work.					
I feel that I have family and friends that I can confide in to assist in managing stress.					
I express my feeling of anger and frustration in ways that are not hurtful to myself or others.					
The level of stress in my work environment is manageable for me.					
I am satisfied with the balance between my work time and leisure time.					

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Health and Habits

In the past week, how many days did you exercise?

How many minutes per week?

What form of exercise do you do?

☐ Walking ☐ Running ☐ Biking ☐ Swimming ☐ Yoga
☐ Weight Training
☐ Other

How do you rate you nutrition?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

I eat at least five servings of fruits and vegetables every day (one serving equals one half cup). ☐ Yes ☐ No

I eat at fast food restaurants less than three times per week. ☐ Yes ☐ No

I maintain a healthy weight within the recommendations specified by a health care professional. ☐ Yes ☐ No

Do you find yourself having trouble hearing people speak? ☐ Yes ☐ No

Do you always use your seat belt in the car? ☐ Yes ☐ No

Function and Mobility

How much difficulty do you have with the following activities?

	I can do this by myself	I need some help to do it	I cannot do this; another person needs to do it for me
Preparing food and eating			
Bathing yourself			
Getting dressed			
Using the toilet			
Shopping			
Using the telephone			
Housekeeping			
Laundry			
Driving or using transportation			
Managing own finances			
Taking your own medications			

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Do you use any devices? (check all that apply)

☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Devices used for dressing
☐ None of the above

In the past year, have you fallen or had a near fall? ☐ Yes ☐ No

Are you afraid of falling? ☐ Yes ☐ No

Physician Signature: _____ Date: _____