Health Risk Assessment

Sound Health Care CENTER

Review of Systems

PATIENT INFORMATION

Full Name	**Date of Birth (mm/dd/yyyy)**	**Today's Date**

Review of Symptoms for Physical Exam *(Circle if present)*	
Constitutional **NONE**	Fatigue Fever/Chills Weight Gain/Loss
Eyes **NONE**	Blurred Vision Dry Eyes Eye Drainage Eye Pain Use of Contacts/Glasses Itchy Eyes Light Sensitivity Last Eye Exam _____
Ears/Nose/Throat **NONE**	Ear Pain Diminished Hearing Ringing Ears Frequent Bloody Nose Nasal Congestion Use of Dentures Hoarseness Post-Nasal Drip Sneezing Oral Sores Sore Throat Sore Tongue Tooth Pain
Cardiovascular **NONE**	Chest Pain/Pressure/Heaviness Palpitations Swelling in Legs Rapid Heart Beat
Respiratory **NONE**	Recent Cough Chronic Cough Shortness of Breath Pain With Deep Breath Wheezing
Gastrointestinal **NONE**	Abdominal Pain Heartburn Poor Appetite Bloating Difficulty/Painful Swallowing Constipation Diarrhea Blood in the Stool Dark or Tarry Stools Hemorrhoids Nausea Vomiting
Urinary/Genital **NONE**	Pain with Urination Lesions on Genitalia Blood in the Urine Unprotected Intercourse History of Frequent UTI Impotence Night Time Urination Frequent Urination Urinary Incontinence
Musculoskeletal **NONE**	Back Pain Neck Pain Arthritis Joint Stiffness Muscle Aches Limb Pain
Skin **NONE**	Acne Abnormal or Changing Moles Dry Skin Fungal Nail Infection Itching Rashes Warts
Neurological (brain) **NONE**	Dizziness Fainting Headaches Memory Loss Numbness Seizures Tremor Vertigo Weakness
Lymphatic/ Hematological (blood) **NONE**	Easy bruising Excessive Bleeding History of Blood Transfusion Swollen Glands
Endocrine (glands) **NONE**	Abnormal Hair Loss Intolerance to Heat/Cold Infertility Excessive Thirst Excessive Sweating
Allergic/Immunologic **NONE**	Seasonal Allergies Year round Allergies History of Allergy Injections
Psychiatric (mental health) **NONE**	Anxiety Apprehension Crying Spells Depression Excessive Stress Irritability Personality Changes Difficulty Concentrating Recreational Drug Use Sadness Insomnia Suicidal Thoughts Mood Swings
Details / Symptoms of Above:	

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Physical Activity

In the past 7 days, how many days did you exercise?

____Days

On days when you exercised, for how long did you exercise (in minutes)?

____Minutes per day, **____Does not apply**

How intense was your typical exercise?

____Light (stretching/slow walking), ____Moderate (brisk walking)

____Heavy (jogging/swimming), ____Very heavy (running/stair climbing), **____ Does not apply**

Tobacco Use

In the last 30 days, have you used tobacco?

____No, **____ Yes**

Used smokeless tobacco product:

____No, **____ Yes**

If yes to either, would you be interested in quitting tobacco use within the next month?

____Yes, **____No**

Alcohol Use

In the past 7 days, on how many days did you drink alcohol?

____days

How often did you have ___(5 or more for men, 4 or more for women and those men and women 65 years old or over)) alcoholic drinks on one occasion?

____Never, ____ Once during the week, ____2-3 times during the week, **____ More than 3 times during the week**

Do you ever drive after drinking, or ride with a driver who has been drinking?

____No, **____ Yes**

Nutrition

In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1cup of fresh/cooked vegetables, or 1 medium piece of fruit: 1 cup is the size of a baseball.)

____Servings per day

In the past 7days, how many servings of high fiber or whole grain foods did you typically eat each day? (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, 1 cup of cooked cereal such as oatmeal, or 1 cup of cooked brown rice or whole wheat pasta.)

____Servings per day

In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken/fish, bacon, chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise)

____Servings per day

In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?

____ Sugar-sweetened beverages consumed per day

Do you take a multivitamin or a vitamin D3 supplement each day?

_____No, **_____ Yes** **Dose of vitamin D3: _____**

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Seat Belt Use
Do you always fasten your seat belt when you are in a car?
___Yes, **___No**

Anxiety
In the past 2 weeks, how often have you felt nervous, anxious, or on edge?
___Almost never, ___Some of the time, ___Most of the time, **___Almost all of the time**
In the past 2 weeks, how often were you not able to stop worrying or control your worrying?
___Almost never, ___Some of the time, ___Most of the time, **___Almost all of the time**

High Stress
How often is stress a problem for you in handling such things as: Your health? Your finances? Your family or social relationships? Your work?
___Never or rarely, ___Sometimes, ___Often, **___Always**

Social/Emotional/Support
How often do you get the social and emotional support you need?
___Always, ___Usually, ___Sometimes, ___Rarely, **___Never**

Pain
In the past 7 days, how much pain have you felt?
___None, ___Some, **___A lot**

General Health
In general, would you say your health is:
___Excellent, ___Very good, ___Good, ___Fair, **___Poor**
How would you describe the condition of your mouth and teeth-including false teeth or dentures?
___Excellent, ___Very good, ___Good, ___Fair, **___Poor**

Activities of Daily Living
In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?
___No, **___ Yes**
In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?
___No, **___ Yes**

Sleep
Each night, how many hours of sleep do you usually get?
___Hours
Do you snore or has anyone told you that you snore?
___No, **___ Yes**
In the past 7 days, how often have you felt sleepy during the daytime?
___Never, ___Rarely, ___Sometimes, ___Usually, **___Always**

Blood Pressure

If your blood pressure was checked within the past year, what was it when it was last checked?

____Don't know/not sure, ____Low or normal (at or below 120/80), ____Borderline high (120/80 to 139/89), **____High (140/90 or higher)**

Cholesterol

If your cholesterol was checked within the past year, what was your total cholesterol when it was last checked?

____Don't know/not sure, _____Not applicable, ____Desirable (below 200),
____Borderline high (200-239), **____High (240 or higher)**

Blood Glucose

If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?

____Don't know/not sure, ____Not applicable, ____Desirable (below 100),
____Borderline high (100-125), **____High (126 or higher)**

If diabetic, and if you have had your hemoglobin A1C level checked in the past year, what was it the last time you had it checked?

____Don't know/not sure, ____Not applicable, ____Desirable (<7.0%),
____Borderline high (7.0% – 8.0%), **____High (>8.0%)**

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Medicare Fall Risk Questionnaire - Patients 65 or older

1. Have you fallen in the past 12 months? YES NO

1a. If yes, how many times have you fallen? _____

1b. How did you fall?

_____

_____

1c. Did you injure yourself and, if so, what was the injury?

_____

_____

2. Can you stand up from a chair without using your arms? YES NO
3. Do you always feel steady when you stand or walk? YES NO
4. Can you balance on one leg? YES NO
5. Do you use a cane or other assistive device to walk? YES NO
6. Do your shoes fit properly? YES NO
7. Can you see well without glasses or bifocals? YES NO
8. Can you hear well in a noisy room? YES NO
9. Do you feel you are as active as you would like to be? YES NO
10. Do you have a nightlight or lamp in your bedroom? YES NO
11. Have you removed all of the throw rugs in your home? YES NO

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐