GLENN MEDICAL CENTER

Patient Name: _____

Date of Birth: _____ Acct: _____

Health Risk Assessment

Circle your responses. Your answers will be kept confidential.

General health

How would you rate your health compared to others your age?	**Worse**	**Same**	**Better**

Hearing and vision

1. Do you feel that a hearing difficulty limits your life?	**Yes**	**No**
2. Do you feel that a vision difficulty limits your life?	**Yes**	**No**

Activities of daily living

1. Do you need help with dressing, eating, bathing, going to the bathroom, walking, or getting in or out of bed?		**Yes**	**No**	
2. Do you need help with preparing meals, transportation, shopping, managing your finances, keeping house, making calls, or taking your medicine?		**Yes**	**No**	
3. If you drive, have you had a car accident in the last year, or have you been asked to stop driving?		**Yes**	**No**	**I do not drive**
4. Who do you live with?	**Alone**	**Partner /spouse**	**Child**	**Parent**
	Other:			
5. Are you working or volunteering?		**Yes**	**No**	
If you do, what do you do, and for how many hours a week?		**< 10**	**11-20**	**21+**

Home safety

Does your home have throw rugs, poor lighting, a slippery bathtub or shower or other hazards?	**Yes**	**No**

Fall risk (STEADI questions — Stopping Elderly Accidents, Deaths and Injuries)

1. Have you fallen in the past year?	**Yes**	**No**
a. If *you have fallen*, how many times?		
b. If *you have fallen*, were you injured?	**Yes**	**No**
2. Do you feel unsteady when standing or walking?	**Yes**	**No**
3. Do you worry about falling?	**Yes**	**No**

▶ **If you answered yes to *any* of the above 3 questions**, please also answer the following:

4. Do you use (or were you told to use) a cane or walker to get around safely?	**Yes**	**No**
5. Do you have to steady yourself by holding onto furniture when moving about your home?	**Yes**	**No**
6. Do you need to push with your hands to stand up from a chair?	**Yes**	**No**
7. Do you have trouble stepping up onto a curb?	**Yes**	**No**
8. Do you often have to rush to the toilet?	**Yes**	**No**
9. Have you lost some of the feeling in your feet?	**Yes**	**No**
10. Do you take any medicine that makes you feel light-headed or tired?	**Yes**	**No**
11. Do you take medicine to help you sleep or improve your mood?	**Yes**	**No**
12. Do you feel sad or depressed?	**Yes**	**No**

Incontinence screening

Do you have trouble holding your bowels or bladder?	**Yes**	**No**

Advance care planning

Do you have an Advance Directive with designation of a Health Care Representative/Power of Attorney?	**No**	**Yes**	**Not sure**

Exercise

How many days a week do you exercise? _____

If you exercise:
What do you do? _____ How many minutes? _____

Nutrition

1. How is your appetite?	**Poor**	**Fair**	**Good**
2. Have you lost weight without meaning to in the last year?	**Yes**	**No**	
3. Do you eat two or more servings of fruits and vegetables every day?	**No**	**Yes**	

Substances

1. Do you smoke or chew tobacco? *If you do*, how much and how often?	**Yes**	**Not currently**	**Never**
2. Do you drink alcohol?	**Yes**	**Not currently**	**Never**
If you drink alcohol, how often and how much?	*I drink…* **Monthly or less** **2-4 times a month 2-3 times a week** **4 or more times a week**		
Standard drinks are 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of liquor each	*I drink…* **1–2 2–4 5–6 7–9 10+** *…drinks in a typical day when I'm drinking.*		
3. Do you use any recreational drugs? *If you've used anything in the last year, please list.*	**Yes**	**Not currently**	**Never**
	Marijuana **Others: _____**		

PHQ 2

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following? *Please circle one response for each question.*	Not at all	Several days	More than half the days	Nearly every day
1. Do you have little interest or pleasure in doing things?	**0**	**1**	**2**	**3**
2. Do you feel down, depressed or hopeless?	**0**	**1**	**2**	**3**

▶ **If the total score from the above questions is 3 or more**, please also answer the following questions:

PHQ 9

	Not at all	Several days	More than half the days	Nearly every day
3. Do you have trouble falling asleep, staying asleep or are you sleeping too much?	**0**	**1**	**2**	**3**
4. Do you feel tired or have little energy?	**0**	**1**	**2**	**3**
5. Do you have poor appetite or overeating?	**0**	**1**	**2**	**3**
6. Do you feel bad about yourself, or feel that you're a failure or have let yourself or your family down?	**0**	**1**	**2**	**3**
7. Do you have trouble concentrating on things, such as reading or watching television?	**0**	**1**	**2**	**3**
8. Do you move or speak so slowly that other people have noticed? Or, the opposite — have you been so fidgety or restless that you have been moving around a lot more than usual?	**0**	**1**	**2**	**3**
9. Have you had thoughts that you would be better off dead, or of hurting yourself?	**0**	**1**	**2**	**3**
10. 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**		**Very difficult**	
	Somewhat difficult		**Extremely difficult**	

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Medicare Wellness: List of Providers & Suppliers of Healthcare

Please list all your current providers and suppliers of healthcare

Primary Care Physician/provider(s):

Clinic/Provider Name	Location

Specialist(s):

Clinic/Provider Name	Location	Specialty

Alternative medicine providers (i.e., chiropractors, acupuncturists, etc.):

Clinic/Provider Name	Location	Specialty

Preferred pharmacy(s): Name & Location

Pharmacy Name	Location

Dentist:

Dentist Name	Location

Other:
