# Annual Health Assessment

Name:
Date:

DOB:

**Please answer all of the questions below.**
**This questionnaire will help us develop a health care plan designed for your needs.**

## General Health

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

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

In general, how satisfied are y
☐ Very satisfied
☐ Satisfied
☐ Dissatisfied
☐ Very dissatisfied

Do you have any problems wi
☐ Yes
D No

Do you have visual problems'
☐ Yes
D No

Do you wear glasses?
☐ Yes
D No

Do you have problems with y
☐ Yes
D No

**Who lives in your home with**

(alone, spouse, significant oth

**Housing Status:**

(own, rent, skilled nursing faci

**Work status:**

Do you currently work:
☐ Yes
D No

Occupation:

Retired?

Disabled from work?

if so why?

Nutrition

Do you follow a specific diet?
☐ Yes
D No

(low fat, low carbs etc.) Which diet?:

In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, 1/2 cup of cooked vegetables, or 1 medium piece of fruit. 1 cup= size of a baseball)
☐ None
☐ 1 serving
☐ 2 servings
☐ 3 servings
☐ 4 servings
☐ More than 4 servings

In the past 7 days, 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, 1/2 cup of oatmeal, 1/2 cup of cooked brown rice, or whole wheat pasta.)
☐ None
☐ 1 serving
☐ 2 servings
☐ 3 servings
☐ 4 servings
☐ More than 4 servings

In the past 7 days, how many nclude fried chicken.fried fish,bacon, trench fries, potat whole milk, cream, cheese or mayonnaise.)
☐ None
☐ 1 serving
☐ 2 servings
☐ 3 servings
☐ 4 servings
☐ More than 4 servings

**Sleep**
How many hours of sleep do
☐ 2-4 hours
D 4-6 hours
D 6-8 hours
☐ 8-10 hours
☐ 10 or more hours

**Activities of Daily Living**
Do you need assistance with
Check device you use:
☐ walker
☐ cane
☐ wheelchair

Are you currently receiving ar
☐ Visiting Nurse
☐ Social Worker
☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy
D Home Health Aid
☐ Adult Day Care Center
☐ Transportation Service
☐ Home Delivered Meds
☐ Homemaker/Chore Service
D **N/A**

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 toilet?
☐ Yes
D No
In the past 7 days, did you need help from others to take care of laundry, housekeeping, banking, shopping, using the telephone, preparing food, transportation, or taking medications?
☐ Yes
D No

Are you concerned that within the next 2 months you may not have stable housing?
☐ Yes
D No
Would you like a referral for assistance?
☐ Yes
D No

Do you have financial strain making it difficult to pay for food, housing and/or basic needs?
☐ Yes
D No
Would you like a referral for assistance?
☐ Yes
D No

How difficult is it to get transportation to and/or from your medical appointments?
☐ does not apply
☐ never
☐ sometimes
☐ often
Would you like a referral for a
☐ Yes
D No

Do you care for an Elder fami
☐ Yes
D No
Would you like a referral for a
☐ Yes
D No

Do you have: Interests, Hobbi
☐ Yes
D No
If yes, what?

Do you have a Health Care P
☐ Yes
D No
Have you appointed a Health
Name of Health Care Agent:

**Do you drive?**
☐ **Yes**
☐ **No**

**Do you ever drive after drinking, or ride with a driver who has been drinking?**
☐ **Yes**
☐ **No**

**Smoking/Tobacco Use**
Do you currently smoke cigarettes or use other types of tobacco?
☐ Yes
D No
Are you a former smoker?
☐ Yes
D No
When did you quit?

Indicate if you currently use any of the other tobacco products?
☐ Cigars
☐ Pipes
☐ Chewing Tobacco/Snuffy
D E-cig

**Alcohol Use/Substance Use**

Do you drink alcohol?
☐ Yes
D No
If yes,
☐ Beer
☐ Wine
☐ Liquor
In the past year, how many times did you have four (for women) or five (for men) drinks per day?

How many times in the last year have you used an illegal drug or used a prescription medication for non-medical reasons?
☐ Never
☐ 1 or more
What type of drug?

Are you or do others have co
☐ Yes
D No

**Caffeine**

Do you use Caffeine daily? (c
☐ Yes
D No
how much/day?

**Physical Activity**

How many days a week do yc
☐ 0 days
D 1 day
☐ 2 days
☐ 3 days
☐ 4 days
☐ 5 days
☐ 6 days
☐ 7 days
and how long do you exercise

min/day

How intense was your typical
☐ Light (stretching or slow wa
☐ Moderate (brisk walking)
☐ Heavy Uogging or swimmir
☐ Very Heavy (fast running or stair climbing)

**Sun Exposure**

Do you protect yourself from the sun when you are outdoors?
☐ Yes
D No

**Safety**

Do you always fasten your seatbelt when you are in a car?
☐ Yes
D No

**Mood**

Over the <u>past 2 weeks,</u> how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things?
☐ Almost all of the time
☐ Most of the time
☐ Some of the time
☐ Almost never

Feeling down, depressed or hopeless?
☐ Almost all of the time
☐ Most of the time
☐ Some of the time
☐ Almost never

Feeling nervous, anxious or on edge?
☐ Almost all of the time
☐ Most of the time
☐ Some of the time
☐ Almost never

Not being able to stop or control worrying?
☐ Almost all of the time
☐ Most of the time
☐ Some of the time
☐ Almost never

Have your feelings caused you distress or interfered with your ability to interact socially with your friends?
☐ Yes
D No

How do you handle the stress
☐ Usually able to cope
☐ At times I have trouble cop
☐ Often have problems copir

Do you often feel alone or lac
DYES
D NO

**On a scale of 0-10(0 being p** **e with your day to day activities? See below and c**
DO
☐ 1
☐ 2
☐ 3
☐ 4
D 5
D6
☐ 7
D8
D9
D 10

Have you fallen 2 or more tir
☐ Yes
D No

**Home Safety**

Does your home have throw r
☐ Yes
D No

Does your home have poor lighting?
☐ Yes
D No

Does your home lack grab bars in the bathroom?
☐ Yes
D No

Does your home lack handrails on stairs?
☐ Yes
D No

Who completed this form today?

Signature

**Thank you for completing this Health Risk Assessment**