MERCYCARE
COMMUNITY PHYSICIANS

Your name: ______________________
Today's date: ______________________
Your date of birth: ______________________

Health Risk Assessment

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health care possible.

1. What is your age?

☐65-69 ☐70-79 ☐80 or older

2. Are you a male or a female?

☐Male ☐Female

3. What is your race? (**Circle all that apply**.)

☐White
☐Black or African American
☐Asian
☐Native Hawaiian or other Pacific Islander
☐American Indian or Alaskan Native
☐Hispanic or Latino origin or descent
☐Other

4. In the **past 12 months**, how often have you:

	0	1-2 times	3-5 times	6 or more
Visited a physician's office/ clinic				
Gone to the Emergency Room				
Stayed overnight in a hospital				

5. Do you have an Advance Directive, Living Will, or IPost?

☐ Yes, Advance Directive or Living Will
☐ Yes, IPOST
☐ No

6. During the **past four weeks**, how much bodily pain have you generally had?

☐ No pain
☐ Very mild pain
☐ Mild pain
☐ Moderate pain
☐ Severe pain

7. During the **past four weeks**, what was the hardest level of physical activity you could do for at least two minutes?

☐Very heavy
☐Heavy
☐Moderate
☐Light
☐Very Light

8. During the **past four weeks**, how would you rate your health in general?

☐Excellent
☐Very good
☐Good
☐Fair
☐Poor

9. During the **past four weeks**, how often have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up					
Sexual problems					
Troubles eating well					
Teeth or denture problems					
Problems hearing over the telephone					
Tiredness or fatigue					
Trouble with bladder control					

10. Do you exercise for about 20 minutes three or more days a week?

☐Yes, most of the time
☐Yes, some of the time
☐No, I usually do not exercise this much

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11. In the **past four weeks,** how often have you had:

	Never	Seldom	Sometimes	Often	Always
Difficulty hearing when someone speaks in a whisper					
Difficulty hearing when listening to TV or radio					
Difficulty with your hearing that limits or hampers your personal or social life					

12. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)

☐ Yes ☐ No

13. Can you go shopping for groceries or clothes without help?

☐ Yes ☐ No

14. Can you prepare your own meals?

☐ Yes ☐ No

15. Can you do your housework without help?

☐ Yes ☐ No

16. Because of any health problems, do you need the help of another person with personal care needs such as eating, bathing, dressing, or getting around the house?

☐ Yes ☐ No

17. Can you handle your own money without help?

☐ Yes ☐ No

18. Are you having difficulties driving your car?

☐ Yes, often
☐ Sometimes
☐ No
☐ Not applicable, I do not use a car

19. Do you fasten your seat belt when you are in a car?

☐ Always ☐ Usually ☐ Sometimes ☐ No

20. Have you fallen two or more times in **the past four weeks**?

☐ Yes ☐ No

21. Are you afraid of falling?

☐ Yes ☐ No

22. Do you have any problems with your hearing?

☐ Yes ☐ No

23. Are you a smoker?

☐ No
☐ Yes, and I might quit
☐ Yes, but I'm not ready to quit

24. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

☐ 10 or more drinks per week
☐ 6-9 drinks per week
☐ 2-5 drinks per week
☐ One drink or less per week
☐ No alcohol at all

25. How often do you have trouble taking medicines the way you have been told to take them?

☐ I do not have to take medicine
☐ I always take them as prescribed
☐ Sometimes I take them as prescribed
☐ I seldom take them as prescribed

26. How confident are you that you can control and manage most of your health problems?

☐ Very confident
☐ Somewhat confident
☐ Not very confident
☐ I do not have any health problems

27. Have you been given any information to help with the following:

Hazards in your house that might hurt you?

☐ Yes ☐ No

Keeping track of your medications?

☐ Yes ☐ No

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28. During the **past four weeks**, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

29. During the **past four weeks**, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself)

- ☐ Yes, as much as I wanted
- ☐ Yes, quite a bit
- ☐ Yes, some
- ☐ Yes, a little
- ☐ No, not at all

30. How have things been going for you during the **past four weeks**?

- ☐ Very well; could hardly be better
- ☐ Pretty well
- ☐ Good and bad parts about equal
- ☐ Pretty bad
- ☐ Very bad; could hardly be worse

31. Please list any specialty doctors you see: _

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32. In the **past four weeks**, how often have you:

	Not at all	Several days	More than half the days	Nearly every day
Had little interest or pleasure in doing things				
Felt down, depressed or hopeless				
Had trouble falling or staying asleep, or sleeping too much				
Felt tired or had little energy				
Experienced poor appetite or over eating				
Felt bad about yourself or that you are a failure or have let yourself or your family down				
Had trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving a lot more than usual.				
Had thoughts that you are better off dead, or thoughts of hurting yourself in some way				