**Health Risk Assessment Questionnaire**

**Please answer the following questions to the best of your ability.**

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| **Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Provider:** | **Dr. Jorge Duchicela** | **Abigayle Adamson, MPAS, PA-C** | |

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| 1. In general, would you say your health is? |  | Excellent |  | Good |  | Fair |  | Poor |
| 1. In general, how would you rate your quality of life? |  | Excellent |  | Good |  | Fair |  | Poor |
| 1. In general, how would you rate your mental health, including your mood and your ability to think |  | Excellent |  | Good |  | Fair |  | Poor |
| 1. How would you describe the condition of your mouth and teeth (including false teeth or dentures)? |  | Excellent |  | Good |  | Fair |  | Poor |

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| 1. In the past 7 days, how much did pain interfere with your day-to-day activities |  | Not at all |  | A little bit |  | Somewhat |  | Very much |
| 1. In the past year, have you had a fall? |  | No falls |  | 1 fall with no injury |  | 2 falls with no injury |  | 2 or more falls with injury |
| 1. In a typical week, how much alcohol do you drink? |  | None |  | 1 drink per day or less |  | 2 drinks per day |  | More than 2 drinks per day |
| 1. Do you currently smoke or have smoked?  Yes |  No | | | | | | | | |
| 1. Do you currently use any other tobacco products such as cigars, pipes, chewing tobacco,   waterpipe, or e-cigarette?  Yes |  No | | | | | | | | |
| 1. Do you usually exercise at least 30mins or more, days a week?  Yes |  No | | | | | | | | |
| 1. Do you usually eat a diet with at least 4 servings of fruit and vegetables,   including whole grains, and fiber, and avoid other than occasional high-fat fat foods?  Yes |  No | | | | | | | | |
| 1. Do you always fasten your seat belt when you are in a car?  Yes |  No | | | | | | | | |
| 1. Do you know where to locate and properly use a first aid kit   and a fire extinguisher in case of an emergency?  Yes |  No | | | | | | | | |
| 1. In the past 7 days have you had any problems with constipation?  Yes |  No | | | | | | | | |
| 1. In the past 7 days have you had any problems staying or falling asleep?  Yes |  No | | | | | | | | |
| 1. Do you or any of your friends or family members have any concerns   about your memory?  Yes |  No | | | | | | | | |
| 1. Do you have any problems with your hearing?  Yes |  No | | | | | | | | |
| 1. Do you have difficulty driving, watching TV, or reading because of your eyesight?  Yes |  No | | | | | | | | |
| 1. In the past 6 months, have you accidentally leaked urine?  Yes |  No | | | | | | | | |
| 1. Does your home have rugs in the hallway?  Yes |  No | | | | | | | | |
| 1. Does your home have grab bars in the bathroom?  Yes |  No | | | | | | | | |
| 1. Does your home have handrails on the stairs?  Yes |  No | | | | | | | | |
| 1. Does your home have good lighting?  Yes |  No | | | | | | | | |

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| 1. What is your walking status? |  | Walk unassisted |  | Use a cane/walker |  | Use a wheelchair |

