**Health Risk Assessment Questionnaire**

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

|  |  |
| --- | --- |
| **Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Provider:**  | [ ]  **Dr. Olga Duchicela**  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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  |

