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Annual Health Risk Assessment

Today's Date: _____

Patient Name: _____**Date of Birth:** _____

Address: _____

Email Address: _____

Home Phone Number: _____ **Mobile Number:** _____

Preferred Contact: ☐ Cell Phone ☐ Home Phone ☐ Direct Mail ☐ Portal

What sex was originally listed on your birth certificate? ☐ Female ☐ Male ☐ Decline to answer

Do you think of yourself as: ☐ Male ☐ Female ☐ Trans Male to Female ☐ Trans Female to Male
☐ Non-binary ☐ Other_____ ☐ Decline to answer

Preferred Gender Pronoun: _____

Sexual Preference: ☐ Straight/heterosexual ☐ Lesbian/gay/homosexual ☐ bisexual
☐ other: _____ ☐ decline to answer

Race: ☐ White ☐ Black/African American ☐ Asian
☐Native Hawaiian/other Pacific Islander ☐ All other ☐ Decline to specify

Ethnicity: ☐ Non-Hispanic ☐ Hispanic **Primary language:** _____

1. Who do you live with? ☐ Alone ☐ With spouse ☐ With child/children ☐ Other_____

2. Considering your age, how would you rate your health? (using a scale of 0-100, 0 being terrible, 100 being perfect, draw a line where you would rate your health.

0--------10---------20---------30---------40---------50---------60---------70---------80---------90---------100

3. Have you had any change in your health in the past year?
☐ Surgery ☐ Hospital stay ☐ Emergency Room or Urgent Care visit ☐ Procedure ☐ Injury or Accident ☐ None
If yes, explain: _____

4. Is your hearing ☐ good ☐ good with hearing aids ☐ fair ☐ poor

5. Is your vision ☐ good ☐ good with glasses ☐ fair ☐ poor

6. In the past 7 days, how many days did you exercise for 30 minutes or more? _____

7. How many hours of sleep do you get each night on average? _____ ☐ **Shift work/sleep** _____**hrs per day**

8. How many healthy meals do you eat daily? _____

9. Have you seen an eye doctor in the last year? ☐ Yes ☐ No **Dentist?** ☐ Yes ☐ No

10. Please list any specialists you see: _____

11. Please list any services you receive at home, such as oxygen, home health nurses, C-pap, etc)
_____

Patient Name: _____ Date of Birth:_____Date visit: _____

Mood Assessment

12. Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things?
☐ not at all ☐ several days ☐ more than 1/2 the days ☐ nearly every day

Feeling down, depressed or hopeless:
☐ not at all ☐ several days ☐ more than 1/2 the days ☐ nearly every day

Feeling anxious or nervous?
☐ not at all ☐ several days ☐ more than 1/2 the days ☐ nearly every day

Not able to stop worrying?
☐ not at all ☐ several days ☐ more than 1/2 the days ☐ nearly every day

13. Have you or a family member experienced a significant loss or stressful event such as a death, move or job loss in the last year?
☐ No ☐ Yes _____

14. In general, how well do you feel you understand your medical condition, how to manage and who to call if there is a problem? ☐ Very well ☐ Somewhat ☐ Not at all

15. Are you currently in recovery for alcohol or substance abuse? ☐ Yes ☐ No

16. In the past week, on how many days did you drink alcohol? ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ I don't drink alcohol

17. On days when you drink alcohol, how much do you normally drink? ☐ 1-2 ☐ 3-4 ☐ 5+

18. In the past year, how many times did you have 4 or more drinks in one day? ☐ none ☐ 1 or more

19. How often do you use nicotine (tobacco) products? ☐ Every day ☐ Some days ☐ Not at all
Do you Vape? ☐ Every day ☐ Some days ☐ Not at all
20. Are you interested in quitting the above products? ☐ Yes ☐ No ☐ Not applicable

21. How many times in the past year have you used an illegal drug or prescription medication for a non-medical reason? ☐ None ☐ 1 or more

22. Do find it difficult to meet your need for food, transportation, housing, utilities, etc ☐ Yes ☐ No

23. Do you ever have a hard time affording your medications? ☐ Yes ☐ No

24. How often does anyone, including family and friends…
Threaten or physically hurt you? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently

25. In general, how satisfied are you with your life (including personal and professional aspects)?
☐ Completely satisfied ☐ Mostly satisfied ☐ Not satisfied

26. In general, how strong are your social ties with family or friends?
☐ Very strong or above average ☐ Average ☐ Weak

27. Do you participate in any activities such as: ☐ Religious Services ☐ Volunteering ☐ Clubs ☐ Hobbies

28. Anyone having sexual contacts or sharing drug needles or equipment may be at risk for HIV/AIDS. Other contact with blood or body fluids may also pose a risk. NYS recommends testing for everyone over age 13 at least once and more often if at increased risk. ☐ I decline testing ☐ I would like to be tested

29. What are your health care or lifestyle goals for the next year?
☐ Quit smoking ☐ Quit or cut down on alcohol ☐ Increase exercise ☐ Eat healthier
☐ Reduce Stress ☐ Decrease blood pressure ☐ Decrease cholesterol
☐ Lose weight ☐ Other _____

Patient Name: _____ Date of Birth:_____Date visit: _____

Please check any symptoms or problems you are having (or none):

General:
☐ fever
☐ night sweats
☐ unexplained weight loss or gain
☐ fatigue
☐ none

Skin:
☐ rashes
☐ itching
☐ changes in hair, skin or nails
☐ none

Ear, Eyes, Nose, Throat:
☐ ear pain
☐ change in hearing
☐ eye problems
☐ persistent runny nose
☐ sore throat
☐ change in voice
☐ sinus trouble
☐ none

Gastrointestinal:
☐ nausea,vomiting
☐ blood in stool
☐ ulcers
☐ change in bowel movements
☐ heartburn
☐ abdominal pain
☐ none

Heart:
☐ chest pain or tightness
☐ swelling in ankles
☐ palpitations, racing heart
☐ none

Lungs:
☐ cough
☐ shortness of breath
☐ wheezing
☐ none

Genital/Urinary:
☐ blood in urine
☐ pain with urination
☐ loss of urine control
☐ none

Women:
☐ vaginal discharge
☐ change in menstrual cycle or sexual function
☐ No problems
Date of last period:_____
What form of birth control do you use? _____
Age at menopause_____☐ not applicable

Orthopedic:
☐ painful or swollen joints
☐ muscle weakness
☐ daily pain
☐ none

Men:
☐ testicular pain
☐ penile discharge
☐ decreased urinary stream
☐ Change in sexual function
☐ None

Neuro/psych:
☐ tremor
☐ frequent headaches
☐ depression
☐ anxiety
☐ none

Please list any other concerns:

Patient Signature:_____Date: _____

Name and relationship of Person Completing the HRA (if not self): _____

Provider Signature: _____ Date:_____