valley MED @ the ten
FAMILY & GENERAL PRACTICE

www.valleymedpc.com
10 Coburg Road, Suite 201
Eugene, OR 97401
P: 541-687-8581
F: 541-343-1411

Health Risk Assessment Form

Patient Name:_____ **DOB:**_____ **Date:**_____

Updating personal/family history:

1) Do you have any new diagnosis that we may not be aware of?	
2) Have any of your immediate family members been newly diagnosed with anything such as Cancer, Diabetes, etc..?	
3) Do you have any personal concerns in regards to your health?	

Tobacco Use:

1) Smoking/Tobacco status: **(This includes smokeless tobacco)**	○ Current ○ Former ○ Never ○ Year Started:_____ ○ If so, years smoked:_____

If current or former tobacco user, please answer questions 2-5. If "NEVER" please skip to question 5

2) How many cigarettes do/did you smoke per day?	_____/day
3) At what time of day do/did you have your first cigarette of the day?	○ Within 5 minutes of waking up ○ 6-30 minutes of waking ○ 31-60 minutes of waking ○ After 60 minutes of waking
4) Would you be interested in quitting?	Yes_____ No_____
5) Do you have current or past use of smokeless tobacco?	Yes_____ No_____
○ **If yes…**	○ what type_____ ○ How many cans per day? _____ ○ Currently using? Yes_____ No_____

Sleep:

1) Each night, how many hours do you sleep?	_____hours
2) Do you snore or has anyone told you that you snore?	Yes_____ No_____
3) How often have you felt sleepy during the daytime?	○ Always ○ Usually ○ Sometimes ○ Rarely ○ Never
4) Do you use a C-PAP machine?	Yes_____ No_____

Hearing:

Do you have troubles with hearing the television or radio when others do not?	Yes_____ No_____
Do you strain or struggle to hear or understand conversations?	Yes_____ No_____
Do you wear a hearing aid?	Yes_____ No_____

Risk for falls:

1) Do you have rugs in your hallway?	Yes_____ No_____
2) Does your home have poor lighting?	Yes_____ No_____
3) Does your home have grab bars in the bathroom?	Yes_____ No_____
4) Does your home have stairs/steps	Yes_____ No_____
5) Does your home have handrails on the stairs/steps?	Yes___ No___ NA___
6) Have you fallen within the past year? ○ If so, how many times?	Yes_____ No_____ _____
7) Do you feel unsteady when you are walking at times?	Yes_____ No_____
8) Do you steady yourself by holding onto furniture when walking at home?	Yes_____ No_____
9) Are you worried about falling?	Yes_____ No_____
10) Do you have trouble stepping up onto a curb?	Yes_____ No_____
11) Do you have to rush to the toilet?	Yes_____ No_____
12) Have you lost the feeling in your feet?	Yes_____ No_____
13) Do you take medications that sometimes make you feel light headed or tired?	Yes_____ No_____

Physical Activity:

1) In the past 7 days, how many days did you exercise?	_____days
2) What type of exercise do you do?	Mark all that apply: Running____ Walking____ Swimming____ Yoga ____ Weightlifting____ Other:_____
3) Do you have trouble maintaining a reasonable weight? ○ If yes, would you like to discuss participation in a program to help?	Yes_____ No_____ Yes_____ No_____
4) How is your ambulation status? (please circle one)	○ Normal/Good ○ Fair ○ Poor
5) Do you have independent ambulation?	Yes_____ No_____
6) Are you non-ambulatory? (unable to walk)	Yes_____ No_____
7) Do you need an assistive device for walking?	Yes_____ No_____ Type:_____

Car Safety:

1) Have you been in a car accident in the last 10 years while YOU were driving? ○ If so, when was the accident?	Yes_____ No_____ _____
2) Do you always fasten your seat belt when in a car?	Yes_____ No_____
3) Have you ever taken an adult driving class, such as AARP Smart Driver Course?	Yes_____ No_____
4) How do you get to the pharmacy to fill your prescriptions?	_____

General Health:

1) Do you have trouble with urinary leakage? ○ If so, would you like to discuss treatment options?	Yes_____ No_____ Yes_____ No_____
2) Do you feel safe in your home?	Yes_____ No_____
3) Do you receive regular dental care?	Yes_____ No_____
4) How would you describe the condition of your mouth and teeth, including false teeth or dentures?	○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
5) Do you have adequate heating and/or air conditioning in your home?	Yes_____ No_____
6) Do you have an Advanced Directive?	Yes_____ No_____
7) Do you have working smoke detectors in your home?	Yes_____ No_____
8) Do you ever have difficulties pick up your chronic medication due to cost?	Yes_____ No_____

Memory:

1) Do you have troubles with any of the following:	
○ Paying bills, writing checks, etc	Yes_____ No_____
○ Playing a game with a skill or hobby	Yes_____ No_____
○ Heating up water, making coffee or turning on the stove	Yes_____ No_____
○ Keeping track of current events	Yes_____ No_____
○ Paying attention to a television program	Yes_____ No_____
○ Discussing a book or TV program	Yes_____ No_____
○ Remembering appointments, family occasions, holidays or taking medications	Yes_____ No_____

Depression or Mood:

Over the last 2 weeks, how often have you been bothered by any of the following: **Please use the following answer key for questions 1-9:** **0 - Not at all** **1 - Several** **2 - More than half the days** 3 **- Nearly everyday**	
1) Little interest or pleasure in doing things	
2)Feeling down, depressed or hopeless	

Anxiety/Stress

Please use the following answer key:

- **0 - Not at all**
- **1 - Several**
- **2 - More than half the days**
- **3 - Nearly everyday**

1) How often have you felt anxious or on edge?	
2) How often were you not able to stop worrying or control you're worrying?	
3) How often is stress a problem for you to handle, regarding: health, finances, family, social groups or work?	
4) How often do you get the emotional support that you need?	○ Always ○ Usually ○ Sometimes ○ Rarely

Alcohol Use:

1) How many times in the past year have you had 5 or more drinks in a day?	○ None ○ 1 or more
2) Do you ever drive after drinking? Or Ride with a driver that has been drinking?	Yes_____ No_____

Drug Use:

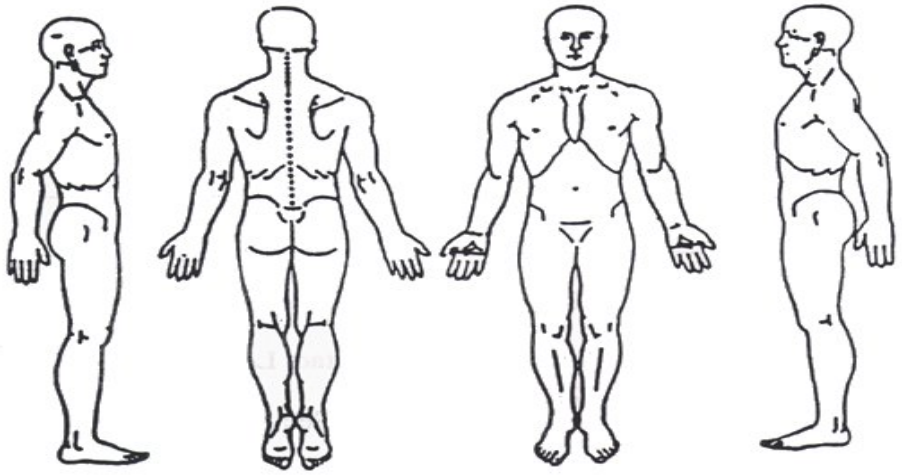
Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana/pot), inhalants (paint thinner, aerosol glue), tranquilizers (valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin)	
1) How many times in the past year have you used a recreational drug or used a prescription medication for a non-medical reasons?	○ None ○ 1 or more

Nutrition:

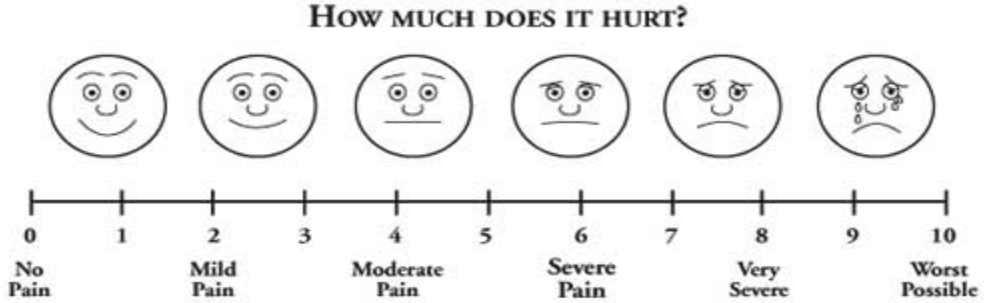
1) How many servings of fruits and vegetables do you typically eat each day? *1 serving= 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit* *1 cup = the size of a baseball*	Servings per day
2) How many servings of high fiber or whole grain foods do you typically eat each day? *1 serving= 1 slice of 100% whole wheat bread, 1cup of whole grain, or high-fiber ready to eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta*	Servings per day
3) How many servings of fried or high-fat foods do typically eat each day? *(Examples include fried chicken, fried fish, bacon, French fries, potato chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese or, mayonnaise.)*	Servings per day
4) How many sugar-sweetened (not diet) beverages do you typically consume each day?	Servings per day

Pain:

1) Do you have chronic pain?	Yes_____ No_____
2) Where is your pain located? (Place an X over any area you have pain)	



3) When was the onset of your pain?	
4) What causes or increases the pain?	
5) What relieves the pain?	
6) What is your current pain level, using the scale **below**:	



COPD Screening:

1) During the last 4 weeks, how much did you feel out of breath?	○ None ○ A little of the time ○ Some of the time ○ Most of the time ○ All of the time
2) Do you ever cough up phlegm or mucus?	○ No, never ○ A little of the time ○ Yes, but only with cold or chest infections ○ Yes
3) Do you do less than you used to because of your breathing?	○ Strongly Disagree ○ Disagree ○ Yes, most of the time ○ Yes, everyday
4) Have you smoked at least 100 cigarettes in your life?	Yes_____ No_____

Using the Key below please indicate one answer by putting an X in the box that indicates your ability to do the following activities.

Key: (0=normal) (1=minimally difficult) (2=moderately difficult) (3=very difficult) (4=unable)

Activity	0	1	2	3	4
1. Sleep normally					
2. Up and down stairs					
3. Food Prep, cooking, eating					
4. Walking					
5. Grooming (bath, comb hair, shave, etc)					
6. Getting up and down from a chair or bed					
7. Dressing –manage normal dressing activity					
8. Dressing – tie shoes, button shirt					
9. Lifting, carrying up to 10 pounds					
10. Sitting for normal periods of time					
11. Standing for normal periods of time					
12. Reaching above head or across body					
13. Leisure, recreational, sports activities					
14. Squatting down to pick up item					
15. Running, jogging					
16. Driving					
17. Job requirements – can do all activities required of my job					