ORANGE FAMILY PHYSICIANS
PATIENT HEALTH RISK ASSESSMENT

Today's Date ____________

Daily Living

Part A: Circle one answer for each of the following statements.

1) I can bathe myself completely or only need help bathing one part of my body, such as my back, genital area or disabled extremity (arm, leg).	YES	NO
2) I can get clothes from closets and drawers. I can put on clothing and outer garments that have fasteners. I may need help tying my shoes.	YES	NO
3) I can go to the toilet, get on and off, clean my genital area, and arrange my clothes without help.	YES	NO
4) I can get in and out of bed or a chair unassisted or with mechanical assistance (such as a seat lift).	YES	NO
5) I can completely control my urination and defecation.	YES	NO
6) I can get food from a plate into my mouth without help.	YES	NO

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Patient Name ______________________________Date of Birth ________________

Part B: For each of the activities such as "Using the phone" or "Shopping" etc, circle the answer that best describes the most that you are able to do.

1) Using the phone
a) Making calls on my own initiative; looking up and calling numbers
b) Calling a few numbers I know
c) Answering the phone, but not making calls
d) I do not use the phone at all

2) Shopping
a) Taking care of all my shopping by myself
b) Shopping independently for small purchases
c) I need someone to go shopping with me
d) I am unable to go shopping

3) Food Preparation
a) Planning, preparing and serving adequate meals independently
b) Preparing adequate meals if supplied with ingredients
c) Heating and serving meals that are already prepared
d) I can prepare meals but have a hard time maintaining an adequate diet
e) I need someone to prepare and serve meals

4) Housekeeping
a) Maintaining my home alone with occasional help for heavy work like vacuuming
b) Performing light daily tasks like dishwashing and bed making
c) I can perform light daily tasks but have a hard time keeping things clean
d) I need help to do all home maintenance tasks
e) I do not participate in any housekeeping tasks

4) Laundry
a) I do all of my personal laundry completely
b) I launder small items, rinse socks or stockings, etc.
c) I need someone to do all of my laundry

5) Transportation
a) Traveling independently on public transportation or driving my own car
b) Arranging travel by taxi, but do not otherwise use public transportation
c) Traveling on public transportation when assisted or accompanied by someone
d) My travel is limited to taxi or car with the assistance of another person
e) I do not travel at all

6) Responsibility for Medications
a) Taking medication in correct dosages at the correct time
b) Taking medication if it is prepared in advance in separate dosages
c) I am not able to dispense my own medication

7) Finances
a) Managing financial matters independently (budgeting, paying bills, banking)
b) Managing day-to-day purchases, but I need help with banking and major purchases
c) I am not able to handle money

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Patient Name ________________________________Date of Birth _________________

Rapid Assessment of Physical Activity

Physical Activities are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work, or transportation. The following questions ask about the amount and intensity of physical activity you usually do. The intensity of the activity is related to the amount of energy you use to do these activities.

Examples of physical activity intensity levels:

Intensity	Examples
Light activities • your heart beats slightly faster than normal • you can talk and sing	Walking Leisurely; Stretching; Vacuuming or Light Yard Work
Moderate activities • your heart beats faster than normal • you can talk but not sing	Fast Walking; Aerobics Class; Strength Training; Swimming Gently
Vigorous activities • your heart rate increases a lot • you can't talk or your talking is broken up by large breaths	Stair Machine; Jogging or Running; Tennis, Racquetball, Pickleball or Badminton

Patient Name ________________________________Date of Birth _________________

Aerobic Activity

Look at the previous page for definitions, then circle one answer below:

1) What are your exercise habits?

a) I do 20 minutes or more a day of **vigorous** physical activities, 3 or more days a week.

b) I do 30 minutes or more a day of **moderate** physical activity, 5 or more days a week.

c) I do **vigorous** physical activities every week, but less than 20 minutes a day or 3 days a week.

d) I do **moderate** physical activities every week, but less than 30 minutes a day or 5 days a week.

e) I do some **light** physical activity every week.

f) I do some **light** or **moderate** physical activities, but not every week.

g) I rarely or never do any physical activities.

Strength and Flexibility

Circle one answer for each of the following statements.

1) I do activities to increase muscle strength, such as lifting weights or calisthenics, once a week or more.	YES	NO
2) I do activities to improve flexibility, such as stretching or yoga, once a week or more.	YES	NO

Nurse Notes:

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Patient Name ________________________________Date of Birth _________________

Nutrition

Circle one answer for each of the following questions.

1) Has your food intake declined over the past 3 months? a) Severe decrease in food intake b) Moderate decrease in food intake c) No decrease in food intake 2) How much weight have you lost in the past 3 months? a) Weight loss greater than 7 pounds b) Do not know the amount of weight lost c) Weight loss between 2 and 7 pounds d) No weight loss or weight loss less than 2 pounds 3) How would you describe your current mobility? a) Unable to get out of a bed, a chair, or a wheelchair without the assistance of another person b) Able to get out of a bed or chair, but unable to go out of my home c) Able to leave my home	4) Have you been stressed or severely ill in the past 3 months? a) Yes b) No 5) Are you currently experiencing dementia and/or prolonged severe sadness? a) Yes, severe dementia and/or prolonged severe sadness b) Yes, mild dementia, but no prolonged severe sadness c) Neither dementia nor prolonged severe sadness

Nurse Notes: Ht _______ Wt _______

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Patient Name _________________________________Date of Birth _________________

Hearing

Check "yes," "no," or "sometimes" in response to each question. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear without the aid.

Question	Yes	Sometimes	No
1) Does a hearing problem cause you to feel embarrassed when meeting new people?			
2) Does a hearing problem cause you to feel frustrated when talking to members of your family?			
3) Do you have difficulty hearing when someone speaks in a whisper?			
4) Do you feel handicapped by a hearing problem?			
5) Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?			
6) Does a hearing problem cause you to attend religious services less often than you would like?			
7) Does a hearing problem cause you to have arguments with family members?			
8) Does a hearing problem cause you difficulty when listening to TV or radio?			
9) Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
10) Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			

Nurse Notes:

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Patient Name ________________________________Date of Birth _________________

Fall Prevention

Circle one answer for each of the following statements.

1) I have fallen in the past year.	YES	NO
2) I use or have been advised to use a cane or walker to get around safely.	YES	NO
3) Sometimes I feel unsteady when I am walking.	YES	NO
4) I steady myself by holding onto furniture when walking at home.	YES	NO
5) I am worried about falling.	YES	NO
6) I need to push with my hands to stand up from a chair.	YES	NO
7) I have some trouble stepping up onto a curb.	YES	NO
8) I often have to rush to the toilet.	YES	NO
9) I have lost some feeling in my feet.	YES	NO
10) I take medicine that sometimes makes me feel light-headed or more tired than usual.	YES	NO
11) I take medicine to help me sleep or improve my mood.	YES	NO
12) I often feel sad or depressed.	YES	NO

Nurse Notes:

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Patient Name _________________________________Date of Birth _________________

Sleep Habits

Circle one answer for each of the following questions.

1) Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	YES	NO
2) Do you often feel tired or sleepy during daytime?	YES	NO
3) Has anyone observed you stop breathing during your sleep?	YES	NO

Nurse Notes: BP________ Ht _______ Wt _______ Age _____

Neck Circumference ______ Gender ______

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Patient Name ________________________________Date of Birth _________________

Behavioral Health

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

Feeling	Not at All	Several Days	More Than Half the Days	Nearly Every Day
1) Little interest or pleasure in doing things				
2) Feeling down, depressed or hopeless				
3) Feeling nervous, anxious or on edge				
4) Not being able to stop or control worrying				

Tobacco Use

Circle one answer for each of the following statements.

1) Have you smoked at least 100 cigarettes in your lifetime?	YES	NO
2) Do you smoke cigarettes?	YES	NO
3) Are you interested in quitting smoking?	YES	NO
4) Do you smoke any other tobacco products?	YES	NO
5) Have you participated in a tobacco cessation program within the last year (12 months)?	YES	NO
6) Does anyone in your household smoke in your presence some days or every day?	YES	NO

Nurse Notes:

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Patient Name ________________________________Date of Birth _________________

Alcohol Use

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest. In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

12 oz. of beer (about 5% alcohol)

=

8-9 oz. of malt liquor (about 7% alcohol)

=

5 oz. of wine (about 12% alcohol)

=

1.5 oz. of hard liquor (about 40% alcohol)

For each question in this chart, place an X in one box that best describes your answer:

Question					
1) How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
2) How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3) How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4) How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5) How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6) How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7) How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8) How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9) Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10) Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink-serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at ***www.who.org***.

Patient Name ________________________________Date of Birth _________________

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List of Medical Providers/Suppliers

Please list the current medical providers and suppliers who are regularly involved in providing medical care to you.

Medical Provider/Supplier Name Address Phone Number	Reason(s)/Indications (e.g., Outpatient Therapy, Dialysis, Specialist, Medical Equipment)

Patient Name ________________________________Date of Birth _________________