Patient name_____DOB_____

ANNUAL HEALTH RISK ASSESSMENT

During the past four weeks, how would you rate your health? ▢ Excellent ▢ Good ▢ Fair ▢ Poor

Which (if any) of the following are problems for you?
▢ I am tired or fatigued ▢ I experience a lot of stress or anger ▢ I am lonely or don't have a lot of support at home ▢ I have difficulty taking or remembering my medicines

Over the past two weeks, have you felt down, depressed or hopeless? ▢ Yes ▢ No

Over the past two weeks, have you felt little interest or pleasure in doing things? ▢ Yes ▢ No

Have you fallen in the past year? ▢ Yes ▢ No

Do you worry that you are at risk of falling? ▢ Yes ▢ No

Do you fasten your seatbelt when you are in a car? ▢ Yes ▢ No

Are you or your loved ones concerned about your memory? ▢ Yes ▢ No

Do you have any sexual problems you would like to discuss? ▢ Yes ▢ No

Do you have trouble with incontinence (leaking of urine)? ▢ Yes ▢ No

Do you need the help of another person to do any of the following? (Check all that apply)
▢ Make meals ▢ Shop for groceries or clothes ▢ Housework ▢ Drive/use public transportation
▢ Use the telephone ▢ Handle finances ▢ Take medications

Do you need the help of another person to do any of the following? (check any that apply)
▢ Eating ▢ Bathing ▢ Dressing ▢ Getting around your home ▢ Laundry ▢ Toileting ▢ Grooming

Do you have any problems with pain? ▢ Yes ▢ No

Do you have any problems with your vision or hearing? ▢ Yes ▢ No

Do you have any problems with your teeth or dentures? ▢ Yes ▢ No

Do you use tobacco (smoking, vaping, chewing)? ▢ Yes ▢ No

How many drinks of wine, beer or other alcoholic beverages do you have per week? ▢ 0-1 ▢ 2-5 ▢ 6+

Do you exercise for 20 minutes, three or more days per week? ▢ Yes ▢ Sometimes ▢ Never

Do you feel safe in your home? ▢ Yes ▢ No

What is your housing situation like? ▢ Live with 1 or more children ▢ Live in an assisted living facility ▢ Live in a nursing facility ▢ Live alone ▢ I have housing today, but I am worried about losing housing in the future ▢ I do not have housing

Do you follow any special diets (low sodium/low sugar)? ▢ Yes ▢ No

If so, what?_____

Do you take any opioid medications? ▢ yes ▢ no

Do you have an Advance Directive? (health care proxy, living will) ▢ yes ▢ no
Would you like to discuss Advance Directives today? ▢ yes ▢ no

HME Review of Systems

Name: _____ DOB: _____ Date: _____

Exercise: Type _____ Min: _____ Per: Day / Week

Sleep: _____ hrs/night Seat belt: Y/N Tobacco/E-cig: ___ /day When start? _____ When quit? _____

Alcohol: _____ drinks/wk Lifetime non-medical drug use: _____

Date of last - Tetanus: _____ Pneumonia: _____ Shingles: _____ Covid complete? Y/N

CURRENT MEDICAL CONCERNS/QUESTIONS: _____

_____

PLEASE CHECK ALL THAT APPLY (Currently or Recently)

- ☐ weight gain
- ☐ weight loss
- ☐ fatigue
- ☐ fever
- ☐ night sweats

- ☐ visual difficulties
- ☐ hearing difficulties
- ☐ ear pain
- ☐ seasonal allergies
- ☐ dental problems

- ☐ chest discomfort
- ☐ rapid or irregular heartbeat
- ☐ swelling in feet/legs

- ☐ cough
- ☐ wheezing
- ☐ shortness of breath
- ☐ snoring
- ☐ sleep apnea

- ☐ nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ abdominal pain
- ☐ change in stool
- ☐ blood in stool
- ☐ reflux/heartburn
- ☐ last colonoscopy/sigmoidoscopy: _____

- ☐ new/changed headache
- ☐ seizure
- ☐ dizziness
- ☐ passing out
- ☐ numbness/tingling
- ☐ tremor/shakiness
- ☐ memory loss
- ☐ weakness

- ☐ easy bruising/bleeding
- ☐ swollen lymph nodes
- ☐ blood clot

- ☐ rash
- ☐ worrisome moles

MEN:

- ☐ penile discharge
- ☐ weakness of urinary stream
- ☐ nighttime urination
- ☐ number of children _____

WOMEN:

- ☐ pregnancies _____
- ☐ number of children _____
- ☐ number of miscarriages _____
- ☐ number of abortions _____
- ☐ painful/heavy periods
- ☐ irregular periods
- ☐ last mammogram _____
- ☐ last PAP _____
- ☐ menopausal symptoms
- ☐ breast lumps
- ☐ date of last period _____

- ☐ muscle pain
- ☐ joint pain

- ☐ gender identity _____
- ☐ sexual orientation _____

- ☐ urinary incontinence
- ☐ painful urination
- ☐ urinary urge/frequency
- ☐ blood in urine
- ☐ sexual difficulties/concerns

- ☐ suicidal thoughts
- ☐ increased stress
- ☐ difficulty sleeping
- ☐ anxiety/nervousness
- ☐ family/marital issues
- ☐ pushed/shoved/harmed?
- ☐ domestic violence
- ☐ eating disorder (past or present)

- ☐ advanced directives
- ☐ living will
- ☐ power of attorney

Personal goals for the upcoming year: _____

_____

Name: _____ DOB: _____

Social Needs Screening Form

		Yes / No
	In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	Y N
	In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?	Y N
	Are you worried that in the next 2 months, you may not have stable housing?	Y N
	Do problems getting child care make it difficult for you to work or study? *(leave blank if you do not have children at home.)*	Y N
$	In the last 12 months, have you needed to see a doctor, but could not because of cost?	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	Y N
	Do you ever need help reading hospital materials?	Y N
	Do you often feel that you lack companionship?	Y N
!	**Are any of your needs urgent?** For example: I don't have food for tonight, I don't have a place to sleep tonight.	Y N
?	If you checked YES to any boxes above, would you like to receive assistance with any of these needs?	Y N

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+
		TOTAL:		

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	_____
Somewhat difficult	_____
Very difficult	_____
Extremely difficult	_____

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A2663B 10-04-2005