Name:_____ Date:_____ MRN:_____

Physician Signature:_____ Date:_____

UAB Huntsville Family Medicine Center Health Risk Assessment

MEDICAL HISTORY

Since your last visit, have you developed any new medical problems?

- □ Yes
- □ No

FAMILY HISTORY

Has anyone in your immediate family developed a medical condition that might affect your health?

- □ Yes
- □ No

SOCIAL HISTORY

Do you need to tell us about any changes in your marital status, family relationships, occupation, education, or personal habits that might affect your health?

- □ Yes
- □ No

MEDICATIONS

Have you been prescribed any new medications by another physician?

- □ Yes
- □ No

Please list:_____

Are you taking any over the counter medications, vitamins, or herbal products?

- □ Yes
- □ No

Please list:_____

Do you need any refills on your prescription medications?

- □ Yes
- □ No

NEW ALLERGIES

Have you developed any new allergies or adverse reactions to medications?

- □ Yes
- □ No

HEALTH CARE PROVIDERS

Please list all your health care providers, such as a dentist, eye doctor, surgeon, heart doctor, lung doctor, stomach/GI doctor, kidney doctor, bladder doctor, orthopedic doctor, or any other specialists. Also list your home health agency, medical supplies provider, etc. You may use the back of this sheet if you need more room.

ADVANCE DIRECTIVES

Do you have a living will, health care power of attorney, or other advance directive?

- □ Yes
- □ No

PHYSICAL ACTIVITY

In the past 7 days, how many days did you exercise? _____days

On days when you exercised, for how long did you exercise (in minutes)? _____minutes per day

- □ Does not apply

How intense was your typical exercise?

- □ Light (like stretching or slow walking)
- □ Moderate (like brisk walking)
- □ Heavy (like jogging or swimming)
- □ Very heavy (like fast running or stair climbing)
- □ I am currently not exercising

Have you fallen down more than twice in the past year?

- □ Yes
- □ No

As an adult, have you had any broken bones?

- □ Yes
- □ No

Does your home lack adequate lighting, properly installed hand rails on steps/stairs, or safety bars in the bathroom?

- □ Yes
- □ No

TOBACCO USE

In the last 30 days, have you used tobacco?
Smoked:

- □ Yes
- □ No

Used a smokeless tobacco product:

- □ Yes
- □ No

If yes to either, would you be interested in quitting tobacco use within the next month?

- □ Yes
- □ No

ALCOHOL USE

In the past 7 days, on how many days did you drink alcohol? _____ days

On days when you drank alcohol, how often did you have (5 or more for men less than 65 years of age, 4 or more for women less than 65 years of age, and 4 or more for anyone 65 years old or over) alcoholic drinks on one occasion?

- □ Never
- □ Once during the week
- □ 2-3 times during the week
- □ More than 3 times during the week

Do you ever drive after drinking, or ride with a driver who has been drinking?

- □ Yes
- □ No

NUTRITION

In the past 7 days, how many servings of fruits and vegetables did 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 = size of a baseball.) _____ servings per day

In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day? (1 serving = 1 slice of 100% whole wheat bread, 1 cup 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

In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressing, and foods made with whole milk, cream, cheese, or mayonnaise.) _____ servings per day

In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day? _____ sugar sweetened beverages consumed per day

SEAT BELT USE

Do you always fasten your seat belt when you are in a car?

- □ Yes
- □ No

ANXIETY

In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

- □ Almost all of the time
- □ Most of the time
- □ Some of the time
- □ Almost never

In the past 2 weeks, how often were you not able to stop worrying or control your worrying?

- □ Almost all of the time
- □ Most of the time
- □ Some of the time
- □ Almost never

HIGH STRESS

How often is stress a problem for you in handling such things as:

- Your health
- Your finances
- Your family or social relationships
- Your work

□ Never or rarely
□ Sometimes
□ Often
□ Always

SOCIAL/EMOTIONAL SUPPORT

How often do you get the social and emotional support you need?

□ Always
□ Usually
□ Sometimes
□ Rarely
□ Never

PAIN

In the past 7 days, how much pain have you felt?

□ None
□ Some
□ A lot

GENERAL HEALTH

In general, would you say your health is?

□ Excellent
□ Very good
□ Good
□ Fair
□ Poor

How would you describe the condition of your mouth and teeth – including false teeth or dentures?

□ Excellent
□ Very good
□ Good
□ Fair
□ Poor

Do you have problems with your vision?

- □ Yes
- □ No

Do you have problems with your hearing?

- □ Yes
- □ No

ACTIVITIES OF DAILY LIVING

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

- □ Yes
- □ No

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

- □ Yes
- □ No

SLEEP

Each night, how many hours of sleep do you usually get? _____ hours
Do you snore or has anyone told you that you snore?

- □ Yes
- □ No

In the past 7 days, how often have you felt sleepy during the daytime?

- □ Always
- □ Usually
- □ Sometimes
- □ Rarely
- □ Never