



Health Risk Assessment

— Confidential —

The following information will be held confidential and will help us assess & accommodate your particular health care needs.

YOUR PERSONAL INFORMATION

Name _____

Address _____ City, State, Zip _____

Home Phone () _____ Work Phone () _____

Date of Birth _____ Today's Date _____

PCP Name _____

PCP Address _____

PCP Phone () _____

What is your primary language?

What is your secondary language?

Do you have any cultural concerns that could interfere with your health care including race, religion, economics, disabilities? _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Relationship _____

Address _____ City, State, Zip _____

Home Phone () _____ Evening Phone () _____

YOUR MEDICAL HISTORY

1. Do you have any of the following health problems? *(Please check all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart or circulation problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stomach or bowel problems | <input type="checkbox"/> Urinary problems (bladder) |
| <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Other health conditions _____ |

YOUR MEDICAL HISTORY (Cont'd)

2. Do you regularly receive any of these special treatments?

- Injections
- Changing of bandages
- Tracheostomy care
- Ostomy care
- Oxygen
- Tube feedings
- Chemotherapy for cancer
- Catheter care
- Other _____

3. List prescriptions and medicine you are currently taking:

Medicine Name	For What Health Condition?
_____	_____
_____	_____
_____	_____
_____	_____

4. During the past 12 months, have you received any of the following health care services?

- Hospital care
- Nursing home or convalescent facility
- Visiting nurse services
- Adult day care
- Emergency care
- Therapist treatment (Physical, Occupational or speech)
- Homemaker services or home health aide
- Other _____
- Rehabilitation center
- Social worker
- Help with transportation

5. Because of a disability or health problem, do you need help with any of the following?

- Using the toilet
- Eating
- Preparing meals
- Managing money
- Using a wheelchair
- Bathing
- Walking
- Shopping for groceries
- Taking medicines
- Other _____
- Dressing
- Getting in or out of bed
- Doing routine housework
- Using the telephone

6. Compared to other persons your age, how would you rate your health? (check one)

- Excellent
- Good
- Fair
- Poor

7. What is your current living status?

- Live alone
- Live with children(s)
- Live with spouse
- Live with other relatives

8. Is there anything else you would like us to know about you?

