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