Health Risk Assessment (HRA) & History

Provider: _____ Health Plan: _____ Date: _____

Name:	Date of Birth:
Reason For Visit:	Gender:
Preferred Pharmacy:	Primary Language:

A. Medical History: Please indicate which of the following medical issues you've had with approximate dates.

Condition	Year	Condition	Year	Preventative Screenings/ Immunizations	Date
___Congestive Heart Failure		___Cancer		**Last Colonoscopy**	
___Heart Attack		___Diabetes		**Last PAP**	
___Stroke		___Thyroid Problem		**Last Mammogram**	
___High Blood Pressure		___COPD		**Last Flu Vaccine**	
___Depression		___High Cholesterol		**Last Pneumonia Vaccine**	
___Chronic Kidney Disease		___Arthritis		**Last Shingles**	
Other:		Other:		**Last Tetanus/ TDAP**	

D. Social History: *Please answer questions 1-12 regarding your social habits.*

(1) Do you exercise regularly? ☐Yes ☐No •If so, what type of exercise and how frequent? _____

(2) What best describes your home environment? ☐Private home ☐Assisted living ☐Other: _____

(3) If at a private home, do you depend on a spouse/family member for assistance? ☐Yes ☐No •If so, who? _____

(4) Do you smoke? ☐Yes ☐No •If so, how many packs/day? _____ •How many years? _____

(5) Do you drink alcoholic beverages? ☐Yes ☐No •If so, how many drinks/month? _____

(6) Do you take recreational drugs? ☐Yes ☐No •If so, how often? _____ •Type? _____

(7) Do you eat a balanced diet? ☐Yes ☐No

(8) Do you have issues with your sexual health? ☐Yes ☐No

(9) Rate your general health? ☐Good ☐Fair ☐Poor

(10) Have you leaked any amount of urine in the last 3 months? ☐Yes ☐No

(11) Are you having difficulties driving your car? ☐ Yes ☐No ☐ N/A – I do not use a car

(12) Do you always fasten your seat belt when you are in a car? ☐Yes, always/usually ☐Yes, sometimes ☐No

E. Family History: Please indicate if you have a blood related relative with any of the following medical issues.

Condition	Relationship	Condition	Relationship	Other/Relationship:
__Heart Disease		__Cancer		1.
__Stroke		__Diabetes		2.
__High Cholesterol		__Glaucoma		3.
__High Blood Pressure		__Alcoholism		4.
__Depression/suicide		__Asthma/COPD		5.

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F. Obstetric and GYN History (FOR WOMEN ONLY):

Event	Date	Event	Number	Other Issues	Y/N
Age of first menstrual		Number of pregnancies		Bleeding Between Periods	
Last menstrual		Live births		Heavy menstrual	
Age menopause began		Miscarriage(s)		Vaginal itching, burning, or discharge	
		Abortions		Breast lump or nipple discharge	
		Cesarean(s)			

G. Hospitalization/Surgery History: Please indicate your hospitalization and surgery history.

Event	Date	Event	Date
1.		4.	
2.		5.	
3.		6.	

H. Patient's medical provider/supplier list: List other physicians/suppliers who provided you care in the past year.

Name	Date	Condition reviewed/ treated	Name	Date	Condition reviewed/ treated
1.			4.		
2.			5.		
3.			6.		

I. Current Medications/Supplements: List all current prescription and non-prescription medicines, vitamins, herbs, etc.

Name	Date last filled	Name	Date last filled
1.		6.	
2.		7.	
3.		8.	
4.		9	
5.		10.	

Medication allergies: _____

Other allergies: _____

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G. Functional Ability/Safety Screening

1. Do you feel unsteady when you walk?	☐ Yes	☐ No
2. Have you recently fallen?	☐ Yes	☐ No
3. Do you need help with eating, getting dressed, grooming, bathing, walking or using the toilet?	☐ Yes	☐ No
4. Does your home have rugs in the hallways, grab bars in the bathrooms, hand-rails on the stairs, proper lighting, smoke and carbon monoxide detectors?	☐ Yes	☐ No
5. Do you need help with the phone, transportation, shopping, preparing meals, house-work, laundry, medications or managing money?	☐ Yes	☐ No
6. Have you noticed vision impairment?	☐ Yes	☐ No
7. **Last Eye Exam?**	Date:	

H. Depression Screening Questionnaire: Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0 points)	Several days (1 point)	More than half the days (2 points)	Nearly every day (3 points)
1. Little interest or pleasure in doing things.				
2. Feeling down, depressed, or hopeless.				
3. Trouble falling or staying asleep, or sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead, or of hurting yourself in some way.				
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?				

*A Healthcare professional will evaluate answers for the questionnaire.

Patient (sign & date): _____