Patient:_____ DOB: _____

ANNUAL HEALTH RISK ASSESSMENT

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 ❒n/a

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

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, 4 or more for women (and those men and women 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 dressings, 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

Depression

In the past 2 weeks, how often have you felt down, depressed, or hopeless?

❒ Almost all of the time

❒ Most of the time

❒ Some of the time

❒ Almost never

In the past 2 weeks, how often have you felt little interest or pleasure in doing things?

❒ Almost all of the time

❒ Most of the time

❒ Some of the time

❒ Almost never

Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?

❒ 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

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

Biometric Measures—Self-Reported

Blood Pressure If your blood pressure was checked within the past year, what was it when it was last checked?

❒ Low or normal (at or below 120/80)

❒ Borderline high (120/80 to 139/89)

❒ High (140/90 or higher)

❒ Don’t know/not sure

Cholesterol

If your cholesterol was checked within the past year, what was your total cholesterol when it was last checked?

❒ Desirable (below 200)

❒ Borderline high (200–239)

❒ High (240 or higher)

❒ Don’t know/not sure

Blood Glucose

If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?

❒ Desirable (below 100)

❒ Borderline high (100–125)

❒ High (126 or higher)

❒ Don’t know/not sure

If diabetic, and if you have had your hemoglobin A1c level checked in the past year, what was it the last time you had it checked?

❒ Desirable (6 or lower)

❒ Borderline high (7)

❒ High (8 or higher)

❒ Don’t know/not sure

Overweight/Obesity

What is your height without shoes? (for example, 5 feet and 6 inches = 5’6”)

Feet _____ Inches _____

What is your weight? Weight in pounds _____