**PATIENT HEALTH RISK ASSESSMENT FORM**

 **FUNCTIONAL STATUS SCREENING**

Bathes on own: Y  N

Toilets on own: Y  N

Transfers on own: Y  N

Dresses on own: Y  N

Eats on own: Y  N

**Mark if you need assistance with:**

Laundry:  Y  N

Shopping: Y  N

Transportation: Y  N

Handling Finances: Y  N

Using The Telephone: Y  N

Meal Preparation:  Y  N

Managing Medications: Y  N

Housework and Basic Home Maintenance: Y  N

**PATIENT SELF ASSESSMENT**

Compared to 1 year ago – I feel my physical health is

     better

     worse

     same

Compared to 1 year ago – I feel my mental health is

     better

     worse

     same

**Tobacco Use**

In the last 30 days have you used tobacco?

Smoked:

     Yes

     No

Smokeless tobacco product

     Yes

     No

If yes to either, are you interested in quitting?

     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) 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

**Depression Screening**

**PHQ -2**

**Over the past 2 weeks, how often have you been bothered by any of the following problems?**

0=Not at all, 1=several days, 2=more than half the days, 3=nearly everyday.

**** 1. Little interest or pleasure in doing things

 2. Feeling down, depressed or hopeless

**FALL RISK AND SAFETY SCREENING**

Have you had any falls in the past year: Y  N

\*If yes, how many 

Were there any injuries associated with fall? 

Mark if you have any impairment of:

     Balance

     Gait

     Vision

     Hearing

     Cognition

     Continence Balance

     NO impairment detected

**PAIN SCREENING**

Do you have pain?

     Yes

     No

If yes, what is the current intensity of pain (0-10) 0=no pain, 10=worst pain 

Pain assessment as clinically appropriate (onset, location, duration, characteristics, aggravating factors, relieving factors, etc) 

**EXERCISE / PHYSICAL ACTIVITY**

How often are you exercising  minutes  times a week

**ADVANCE CARE PLANNING**

We will be discussing this with you at your visit. However, if you have an up to date advanced care planning, please bring it with you to your visit.

**List of Specialists, DME and home health**

**SPECIALIST**

Cardiology - Specialist Name 

Ophthalmology / Optometrist - Specialist Name 

Dermatology - Specialist Name 

Urology - Specialist Name 

Orthopedic - Specialist Name 

Neurology - Specialist Name 

Endocrinology - Specialist Name 

Pulmonology - Specialist Name 

Sleep Medicine - Specialist Name 

Vascular Surgeon - Specialist Name 

Gastroenterology (GI) - Specialist Name 

Gynecologist - Specialist Name 

Allergy / Immunology - Specialist Name 

Hematology / Oncology - Specialist Name 

Specialty  Specialist Name 

Specialty  Specialist Name 

Specialty  Specialist Name 

Specialty  Specialist Name 

Specialty  Specialist Name 

Specialty  Specialist Name 

**Durable Medical Equipment / DME (CPAP, Oxygen, etc)**

Company Name   Services provided (CPAP, Oxygen, wheelchair, etc) 

Company Name   Services provided (CPAP, Oxygen, wheelchair, etc) 

Company Name   Services provided (CPAP, Oxygen, wheelchair, etc) 

Company Name   Services provided (CPAP, Oxygen, wheelchair, etc) 

**HOME HEALTH**

Company Name 