Burrows Family Practice, Inc.

Sr. Health Risk Assessment Questionnaire

Date:_____

Patient Name:_____ Date of Birth_____

In general would you say your health is ◯ Excellent ◯ Very Good ◯Good ◯ Fair ◯Poor

Functional Evaluation

Do you live alone? □ Yes □ No, if No who do you live with? _____
Check if you need assistance in any of the following areas? ◯ Bathing ◯ Dressing
◯ Eating ◯ Walking ◯ Toileting ◯ Shopping ◯ Driving/using public transport
◯ Laundry ◯ Housework ◯ Handling Finances ◯ Using telephone

Home Safety Assessment

Do you have easy access to a phone at home? □ Yes □ No
Do you have a functioning carbon monoxide alarm in your home? □ Yes □ No
Do you have a functioning smoke alarm in your home? □ Yes □ No

Hearing Assessment

Do you have trouble hearing the television or radio when others do not? □ Yes □ No
Do you have to strain or struggle to hear or understand conversations? □ Yes □ No

Balance Assessment

Have you fallen in the past year? □ Yes □ No, If Yes, how many times? □ 1 □ >2

OFFICE STAFF TO COMPLETE THIS SECTION

◯ Normal ◯ Requires minimal assistance ◯ Unsafe, requires moderate assistance ◯ Requires maximum assistance to reduce fall risk

Pain Assessment

How often have you had pain during the past 3 months?
◯ not at all ◯ some days ◯ most days ◯ every day
How often during the past 3 months has pain kept you from doing activities you enjoy?
◯ not at all ◯ some days ◯ most days ◯ every day

PATIENT SIGNATURE_____ PROVIDER SIGNATURE_____

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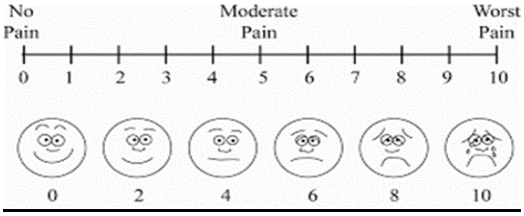
Sept 2019 VERSION 2.0

please mark with an X current pain level if applicable in the pain scale shown below

0-10 Numeric Pain Rating Scale



Exercise Frequency

How intense is your typical exercise? (Check one) ___I am currently not exercising ___ Light (like stretching or slow walking) ___Moderate (like brisk walking) ___Heavy (like jogging or swimming) ___Very heavy (like fast running or stair climbing)

Depression Screening-PHQ9

Over the last 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

***Little interest or pleasure in doing things you once enjoyed_____**
***Feeling down, depressed or hopeless ____**
***Trouble falling or staying asleep, or sleeping too much_____**
***Feeling tired or having little energy_____**
***Poor appetite or overeating_____**
***Feeling bad about yourself-or that you are a failure or have let yourself or your family down____**
***Trouble concentrating on things, such as reading the newspaper or watching television_____**
***Moving or speaking so slowly that other people could have noticed, or the opposite- being so fidgety or restless, and you are moving around more than usual_____**
***Thoughts that you would be better off dead, or thoughts of hurting yourself in some way_____ PHQ-9 SCORE /27**

Alcohol Assessment **C.A.G.E**

Do you consume alcohol? □ Yes □ No

If yes, please answer the following questions below. Thank you!

C - Have you ever felt you should *cut down* on your drinking? □ Yes □ No
A - Have people *annoyed* you by criticizing your drinking? □ Yes □ No
G- Have you ever felt bad or *guilty* about your drinking? □ Yes □ No
E- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? (*Eye opener)* □ Yes □ No

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Habit Assessment

Tobacco(chew, cigar,pipe,cigarette)	**Do you use tobacco products now or in the past? □ Yes □ No** **Number of years:_____ Number of packs per day:_____** **□ Former Smoker Quit Date_____**
Nicotine (vape)	**□ Never □ Current □ Former**
Recreational Drugs	**□ Never □ Current □ Social/Occasional** **What drug(s)? _____** **□ Former User** **What drug(s)? _____**

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TB Risk Assessment

Date: _____

Patient Name: _____ Date of Birth_____

Do you currently have any of the following symptoms ◯ Yes ◯ No
□ prolonged cough >3 weeks □ coughing up blood □ unexplained weight loss
□ chronic fever □ drenching night sweats

In the past 2 years….
Have you had any contact with someone with known TB disease of the lung? □ Yes □ No
Spent more than 2 weeks in Asia, Africa, Latin America or Eastern Europe? □ Yes □ No
Been in prison or jail? □ Yes □ No
Been homeless? □ Yes □ No
Injected street drugs? □ Yes □ No
Worked with homeless persons, migrant works or drug users? □ Yes □ No
Worked as a healthcare worker? □ Yes □ No

**** TB test is needed if the answer is YES to any of the above questions. Proceed with office protocol at that point. If the answer is NO then no further action is required.**

Patient Signature_____

Provider Signature_____