

Health Risk Appraisal

Name: _____ Appraisal Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Source of Information: (ex: consumer, parent/guardian/caretaker, PCP, Other): _____

1 Do you have any of the following medical conditions?

_____ Diabetes _____ Emphysema/COPD _____ Asthma
_____ High Blood Pressure _____ Heart Disease _____ High Cholesterol

Please list any other physical health challenges that you feel is important for us to know:

2) Do you have or need any of the following:

Primary Care Physician _____ Has _____ Needs Dentist _____ Has _____ Needs
Eye doctor _____ Has _____ Needs Audiologist _____ Has _____ Needs
Medical Equipment _____ Has _____ Needs
Other Specialist _____ _____ Has _____ Needs

3) Are you on 4 or more medications? Yes or No

4) Are you on medications that are not prescribed at this agency? Yes or No

5) Do you use any special medical equipment in your home? Yes or No

6) Do you use any mobility tools? Yes or No

7) Have you been to an emergency room within the last 3 months? Yes or No

8) Have you been in the hospital in the last 3 months? Yes or No

9) Do you see more than one doctor other than us? Yes or No

10) Do you smoke or use other tobacco products? Yes or No

11) Do you want help to quit? Yes or No

12) Do you worry that you use too much alcohol or drugs? Yes or No

13) Has a doctor ever told you that you are overweight? Yes or No

14) Do you want help to lose weight? Yes or No

15) How would you rate your overall health and wellness?

(0 = not at all; 10 = completely satisfied)

