Annual Wellness Visit Health Risk Assessment

To Our Patients:

This Health Risk Assessment Questionnaire is part of your upcoming Wellness Visit. Please answer the following questions about your health and day to day activities.

This questionnaire will help your clinical team address the areas important to your overall well-being.

This questionnaire should take about 5 minutes to complete.

If you need help, please contact our office, or ask for help during your visit.

Thank you.
Please answer the following questions to the best of your ability.

1. In general, how would you rate your overall health?
   - [ ] Excellent
   - [ ] Very Good
   - [ ] Good
   - [ ] Fair
   - [ ] Poor

2. In general, how would you rate your quality of life?
   - [ ] Excellent
   - [ ] Very Good
   - [ ] Good
   - [ ] Fair
   - [ ] Poor

3. In general, how would you rate your mental health?
   - [ ] Excellent
   - [ ] Very Good
   - [ ] Good
   - [ ] Fair
   - [ ] Poor

4. In the past 7 days, how much did your pain interfere with your day to day activities?
   - [ ] Not at all
   - [ ] A little bit
   - [ ] Somewhat
   - [ ] Quite a bit
   - [ ] Very much

5. Over the last two weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Feeling down, depressed or hopeless</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
6. Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person

<table>
<thead>
<tr>
<th>Activity</th>
<th>I do not have difficulty</th>
<th>Yes, I have difficulty</th>
<th>I am not able to do this activity unassisted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing and grooming</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using the toilet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting in and out of bed or chairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing money</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household activities, like food prep, laundry, and housekeeping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you shop for groceries and clothes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you get to places out of walking distance?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. In the past 6 months, have you accidentally leaked urine?

☐ Yes  ☐ No

8. A fall is when your body goes to the ground without being pushed. Did you fall in the past 12 months?

☐ Yes  ☐ No

If yes, how many times?_________ Were you injured?_________

Do you feel unsteady when standing or walking?

☐ Yes  ☐ No

Do you worry about falling?

☐ Yes  ☐ No
9. What is your walking status?

- ☐ Walk unassisted
- ☐ Use a cane or walker
- ☐ Use a wheelchair

10. Do you think you have a hearing problem, or do others think you have a hearing problem?

- ☐ Yes
- ☐ No

11. Do you wear hearing aids?

- ☐ Yes
- ☐ No

12. Do you have difficulty driving, watching TV, reading, or doing any of your daily activities?

- ☐ Yes
- ☐ No

13. How is your appetite?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

14. How many servings of fruits and vegetables do you eat on a typical day?

- ☐ More than 5 servings
- ☐ 3-5 servings
- ☐ 1-2 servings
- ☐ I do not eat fruit and vegetables

15. Does the place where you live have the following safety concerns addressed?

<table>
<thead>
<tr>
<th>Safety Concern</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loose rugs secured</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Carbon Monoxide detector</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Working smoke alarm</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Good lighting in walkways</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Solid hand rails on stairs</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Non-slip flooring in tub or shower, or grab bars</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
15. What is your usual form of transportation?

- [ ] Drive self
- [ ] Driven by others
- [ ] Bus/taxi/paratransit

16. Is your Advance Healthcare Directive on file with us?

- [ ] Yes
- [ ] No

17. In the past four weeks, would there have been someone available (family, friend, etc.) to help you if you would have needed and wanted the help? For example. If you felt lonely, depressed, got sick and needed to stay in bed, needed help with daily chores, or just needed to take care of yourself.

- [ ] Yes, as much as needed
- [ ] Yes, quite a bit
- [ ] Yes, some
- [ ] Yes, a little
- [ ] No, not at all

18. How many days per week do you usually exercise? _________

19. If you exercise, on average, how long is your exercise session? _________

20. How intense is your physical exercise?

- [ ] Very heavy running, stair climbing
- [ ] Heavy jogging, swimming
- [ ] Moderate brisk walking
- [ ] Light stretching or slow walking

21. In a typical week, how many days do you drink alcohol (beer, wine, liquor, cocktails)? _________ day(s) a week

22. On days when you do drink how many alcoholic drinks do you consume? _________
   (one drink= 12 oz of beer, 5 oz. of wine, or 1.5 oz. of distilled spirits)

23. What is the most number of drinks you’ve had in one day in the past 6 months? _________
24. To ensure optimal care coordination, please list below all providers you see on a regular basis.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please wait for your provider to complete this portion

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