HRA Patient Questionnaire

MEMBER NAME: _____

GENDER: Female AGE: _____ DOB: _____

Please list your Medical Providers

1. _____
2. _____
3. _____
4. _____

General health

1. In general, would you say your health is?
   □ Excellent □ Very good □ Good □ Fair □ Poor

2. How would you describe the condition of your mouth and teeth, including false teeth or dentures?
   □ Excellent □ Very good □ Good □ Fair □ Poor

Alcohol Use

1. In the past 7 days, on how many days did you drink alcohol? ____ Days
2. On days when you drank alcohol, how often did you have 4 or more alcoholic drinks on one occasion?
   □ Never □ Once during the week □ 2-3 times during the week
   □ More than 3 times during the week □ Not applicable

3. Do you ever drive after drinking, or ride with a driver who has been drinking?
   □ Yes □ No

Pain

1. In the past 7 days, how much pain have you felt? □ None □ Some □ A lot

Physical Activity

1. In the past 7 days, how many days did you exercise? ____ Days
2. On days when you exercised, for how many minutes did you exercise? _____
3. How fast do you feel you walk? □ Slow □ Medium □ Fast
4. Have you had any recent unintended weight loss? □ Yes □ No
5. Do you often feel exhausted? □ Yes □ No
6. How much energy do you feel you have? □ Low □ Medium □ High
7. Do you often feel weak? □ Yes □ No

Sleep

1. Each night, how many hours of sleep do you usually get? _____ hours
2. Do you snore or has anyone told you that you snore? □ Yes □ No

Tobacco Use

1. In the last 30 days, have you smoked tobacco? □ Yes □ No
2. Do you use a smokeless tobacco product? □ Yes □ No
3. If yes to either question about tobacco use, would you be interested in quitting tobacco use within the next month? □ Yes □ No □ Not applicable

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Nutrition

1. In the past 7 days, how many servings of fruits _____ & vegetables_____ did you typically eat each day?

2. In the past 7 days, how many servings of whole grain foods did you typically eat each day (bread, cereal, oatmeal, **brown** rice or whole wheat pasta) _____

3. In the past week, how many sugar-sweetened (not diet) beverages did you drink each day? _____

High Stress

1. How often is stress a problem for you in handling such things as your health, finances, family or social relationships, or work?
   □ Almost all of the time □ Most of the time □ Some of the time □ Almost never

2. Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?
   □ Almost all of the time □ Most of the time □ Some of the time □ Almost never

3. 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

4. In the past 2 weeks, how often have you felt angry?
   □ Almost all of the time □ Most of the time □ Some of the time □ Almost never

5. In the past 7 days, how often have you felt sleepy during the daytime?
   □ Almost all of the time □ Most of the time □ Some of the time □ Almost never

6. How often do you get the social and emotional support you need?
   □ Almost all of the time □ Most of the time □ Some of the time □ Almost never

7. 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

Activities of Daily Living

1. 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

   If yes, please describe: _____

   _____

2. During the last 3 months, have you leaked urine (even a small amount)?
   □ Yes □ No

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Instrumental Activities of Daily Living

1. In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, shopping, using the telephone, food preparation, transportation, or taking your own medications?
   ☐ Yes ☐ No

   If yes, please describe: _____

   _____

Vaccinations:

1. Do you get a yearly flu shot? ☐ Yes ☐ No
2. Have you had a pneumonia shot? ☐ Yes ☐ No If yes, when? _____
3. Have you had a shingles shot? ☐ Yes ☐ No If yes, when? _____
4. Have you had a tetanus shot? ☐ Yes ☐ No If yes, when? _____

Injury Risks

1. Do you live alone? ☐ Yes ☐ No
2. Do you have stairs in your home? ☐ Yes ☐ No
3. Do you have carpet flooring? ☐ Yes ☐ No
4. Do you have area rugs? ☐ Yes ☐ No
5. Do you often feel unsteady when you walk? ☐ Yes ☐ No
6. Do you feel dizzy or lightheaded? ☐ Yes ☐ No
7. Do you fall often? ☐ Yes ☐ No If yes, cause? _____
8. While walking, do you worry about falling? ☐ Yes ☐ No
9. Do you have smoke detectors in your home? ☐ Yes ☐ No
10. Do you have carbon monoxide detectors in your home? ☐ Yes ☐ No
12. Do you drive? ☐ Yes ☐ No
13. Do you wear seatbelts? ☐ Yes ☐ No
14. Do you feel you can safely operate a car? ☐ Yes ☐ No

Depression screening

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

1. Little interest or pleasure in doing things ☐ 0 ☐ 1 ☐ 2 ☐ 3
2. Feeling down, depressed, or hopeless ☐ 0 ☐ 1 ☐ 2 ☐ 3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

I understand this form is just one component of my Health Risk Assessment and Annual Well Visit. I agree to the completion of my Annual Well Visit as provided by the staff and physician.

Patient signature _____ Date _____