PARTNERS IN FAMILY HEALTH
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THESE FORMS MUST BE COMPLETED PRIOR TO YOUR APPOINTMENT. IF YOU DO NOT BRING THIS FORM AND/OR ALL OF YOUR MEDICATIONS, YOUR APPOINTMENT WILL BE RESCHEDULED.

Please list all of your doctors and healthcare providers:

Name: Partners in Family Health Specialty: Primary Care Provider

Name: _____ Specialty: Eye Care Professional

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

List all of your medications – include vitamins, supplements, Over-the-Counter medications taken regularly and herbal

We have provided a list of the active medications we have on file for you. If correct, you need to do nothing further. Please make corrections & additions if needed. Use the back of this form for additional space.

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Date: _____

Also, place ALL of your medications in a bag and bring them with you to the office.

Sometimes, patients receive services provided or ordered *by other healthcare professionals.*

As your Primary Care Provider, it is important that we document these services in your medical record.

(CIRCLE ONE)

Are there any preventive tests you have done recently? **YES** **NO**
(Examples: lab tests, mammogram, x-rays)

1. _____
2. _____
3. _____

Have you had any recent immunizations? **YES** **NO**

1. _____
2. _____
3. _____

Do you have a living will or advance directive? **YES** **NO**
(If you have one, please bring it with you.)

RISK ASSESSMENT

COMPLETE THIS HEALTH ASSESSMENT AND BRING IT WITH YOU TO YOUR APPOINTMENT.

IF THIS IS NOT COMPLETED, YOUR APPOINTMENT WILL BE RESCHEDULED.

DATE:

HEALTH RISK ASSESSMENT FOR:

DATE OF BIRTH:

1. BEHAVIOR RISK FACTORS

Physical Inactivity / Lack of Exercise

How many days a week do you usually exercise?

____ days per week

On days when you exercise, for how long do you usually exercise?

____ minutes per day ____ does not apply

How intense is your typical exercise? (check one)

____ Light (like stretching of slow walking)

____ Moderate (like brisk walking)

____ Heavy (like jogging or swimming)

____ Very heavy (like fast running or stair climbing)

____ I am currently not exercising

Smoking / Tobacco Use

Do you currently smoke cigarettes or use other types of tobacco? (check one)

____ Yes ____ No

Are you a former smoker?

____ Yes, and I quit ____ No, I've never smoked ____ Does not apply

If you quit smoking, how long ago did you quit smoking cigarettes?

____ Less than 6 months ago ____ 6-10 years ago

____ 6-11 months ago ____More than 10 years ago

____ 1-5 years ago ____ Does not apply

Do you use these other tobacco products? (check all that apply)

____ Cigars ____ Pipes

____Chewing tobacco / snuff ____ I use no other tobacco products

Alcohol Use

In a typical week, how many days do you drink alcohol?

____ days per week

On days when you drink alcohol, how many alcoholic drinks do you consume?

____ drinks per day

In a typical week, how often do you have 5 or more alcoholic drinks on one occasion?

____ Never ____ 2-3 times per week

____ Once a week ____ More than 3 times per week

Nutrition

On a typical day, how many servings of fruits and/or vegetables do you eat?

1 serving = 1 cup of fresh vegetables, 1/2 cup of cooked vegetables, or 1 medium piece of fruit
1 cup = size of a baseball

____ servings per day

On a typical day, how many servings of high fiber or whole grain foods do you eat?

> **1 serving** = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, 1/2 cup of cooked cereal such as oatmeal, or 1/2 cup of cooked brown rice or whole wheat pasta

____ servings per day

On a typical day, how many servings of fried or high-fat foods do you eat?

> Examples include: fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise

____ servings per day

Motor Vehicle Safety

Do you always fasten your seat belt when you are in the car?

____ Yes ____ No

Do you ever drive after drinking, or ride with a driver who has been drinking?

____ Yes ____ No

Sun Exposure

Do you protect yourself from the sun when you are outdoors?

____ Yes ____ No

2. **BIOMETRIC MEASURES (SELF REPORTED)** ***We are interested in knowing how much YOU know about your health status.***

Blood Pressure

If your blood pressure was checked within the past year, what was it when it was last checked?

____ Low or normal (at or below 120/80)
____ Borderline high (120/80 to 139/89)
____ High (140/90 or higher
____ Don't know / not sure
____ Does not apply

Cholesterol

If your cholesterol was checked within the past year, what was your total cholesterol when it was last checked?

____ Desirable (Below 200)
____ Borderline high (200-239)
____ High (240 or higher)
____ Don't know / not sure
____ Does not apply

Blood Glucose

If your glucose was checked within the past year, what was your fasting blood glucose (blood sugar) level the last time it was checked?

____ Desirable (Below 100)
____ Borderline high (100-125)
____ High (126 or higher)
____ Don't know / not sure
____ Does not apply

Have you ever been told by a doctor or a health professional that you have diabetes or high blood sugar?

____ Yes ____ No (skip to next section)

If you have had your hemoglobin A-1C level checked within the past year, what was it the last time you had it checked?

____ Desirable (6 or lower)
____ Borderline high (7)
____ High (8 or higher)
____ Don't know / not sure
____ Does not apply

Overweight / Obesity

What is your height? Example: 5 feet, 6 inches = 5'6"

_____ Feet _____ Inches

What is your weight?

_____ Pounds

3. PSYCHOSOCIAL RISK FACTORS

Depression

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

_____ Almost all of the time _____Some of the time

_____ Most of the time _____ Almost never

Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?

_____ Almost all of the time _____ Some of the time

_____ Most of the time _____ Almost never

Have your feelings caused you distress or interfered with your ability to interact socially with friends?

_____ Yes _____ No

During the past 6 months, how often have you felt sad or depressed?

_____ Almost all of the time _____ Some of the time

_____ Most of the time _____ Almost never

In general, how satisfied are you with your life?

_____ Very satisfied _____ Dissatisfied

_____ Satisfied _____ Very dissatisfied

High Stress

How often is stress a problem for you?

____ Never / rarely

____ Sometimes

____ Often

____ Always

How well do you handle the stress in your life?

____ I'm usually able to cope effectively

____ At times I have problems coping

____ I often have problems coping

General Well-Being

In general, would you say your health is

____ Excellent

____ Very good

____ Good

____ Fair

____ Poor

Social / Emotional Support

How often do you get the social and emotional support you need:

____ Always

____ Usually

____ Sometimes

____Rarely

____ Never

General Life Satisfaction

In general, how satisfied are you with your life?

____ Very satisfied

____ Satisfied

____ Dissatisfied

____ Very dissatisfied

Sleep

How many hours of sleep do you usually get each night?

_____ Hours

4. CHEMOPROPHYLAXIS

Daily Aspirin Use

Have you discussed taking a daily aspirin with your doctor?

_____ Yes _____ No