

## HEALTH RISK APPRAISAL

1. Name \_\_\_\_\_  
 2. Date of Birth: \_\_\_\_\_ 3. Today's Date: \_\_\_\_\_  
 Health Center:  Beckwith  Cascade  Jenison  Kentwood  
 Rockford  Sparta  Walker  Wyoming

5. Sex:  Male  Female  
 6. Marital Status:  Single  Married  Separated/Divorced  
 7. Education:  HS  Tech. School  College: Degree \_\_\_\_\_  
 8. Occupation: \_\_\_\_\_

9. Please indicate by checking the box next to the following conditions if you or your parents (M,F), grandparents (GP), brothers (B), and sisters (S) have ever had or currently have:

	<b>YOU</b>		<b>YOUR FAMILY</b>
Disease	Year Diagnosed	Disease	Relationship (M, F, GP, B, S)
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Cancer: Type _____	_____	<input type="checkbox"/> Cancer: Type _____	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> High Cholesterol	_____
<input type="checkbox"/> Heart Problems	_____	<input type="checkbox"/> Heart Attack/Failure	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Emphysema	_____	<input type="checkbox"/> Emphysema <input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Alcohol or Drug Abuse	_____	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drug Abuse	_____
<input type="checkbox"/> Mental Illness	_____	<input type="checkbox"/> Mental Illness <input type="checkbox"/> Suicide	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Glaucoma	_____
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Arthritis	_____

10. Please list all hospitalizations or surgeries you have had:

OPERATIONS / ILLNESSES / PREGNANCIES	YEAR	HOSPITAL

11. List all medications you are currently taking on a regular basis (include non-prescription medications, herbal medicines, minerals and vitamins)

MEDICATION	DOSE	MEDICATION	DOSE

12. List all medications you are allergic to: \_\_\_\_\_

13. How long has it been since your last physical examination?  less than 1 yr.  1-2 yrs.  3-5 yrs.  more than 5 yrs.

14. Check off any of the following statements that apply to you:

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> I am having unusual vaginal bleeding</li> <li><input type="checkbox"/> I have a breast lump or nipple discharge</li> <li><input type="checkbox"/> I have a lump on my testicle</li> <li><input type="checkbox"/> I have had a big change in my bowels recently</li> <li><input type="checkbox"/> I have rectal bleeding</li> <li><input type="checkbox"/> I have a sore that bleeds or a mole that is changing</li> <li><input type="checkbox"/> I have unexplained weight loss (20 lb. or more)</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> I am having chest pain with exercise</li> <li><input type="checkbox"/> I have severe shortness of breath</li> <li><input type="checkbox"/> I have been spitting up blood</li> <li><input type="checkbox"/> I want a test for HIV (AIDS) or other STD infection</li> <li><input type="checkbox"/> I need birth control information</li> <li><input type="checkbox"/> I feel very depressed</li> <li><input type="checkbox"/> I want to talk to someone about a very personal problem</li> </ul> |
|---|--|

**For the following questions, answer as many as possible as best you can. If you do not know the answer, leave it blank.**

15. What is your weight? (without shoes, no fractions).....  feet  inches
16. What is your weight? (without shoes, no fractions).....  pounds
17. What is your body frame size?.....  
1  small  
2  medium  
3  large
18. What is your blood pressure now?.....  systolic  diastolic  
(high number) (low number)
19. If you do not know your blood pressure numbers, check the box that describes your blood pressure.....  
1  high  
2  low or normal  
3  don't know
20. What is your total cholesterol level? (based on a blood test).....  mg/dl
21. What is your HDL cholesterol level? (based on a blood test).....  mg/dl
22. How many cigars do you usually smoke per day?.....  cigars per day
23. How many pipes of tobacco do you usually smoke per day?.....  pipes per day
24. How many times per day do you usually use smokeless tobacco? (chewing tobacco, snuff, pouches, etc.).....  times per day
25. How would you describe your cigarette smoking habits?.....  
1  still smoke (go to 26)  
2  used to smoke (go to 27)  
3  never smoked (go to 28)
26. (Still smoke) How many cigarettes per day do you smoke?.....  per day (go to 28)
27. (Used to smoke)  
a. How many years has it been since you smoked fairly regularly?  years  
b. What was the average number of cigarettes per day that you smoke in the two years before you quit?.....  cigarettes per day
28. In the next 12 months how many thousands of miles will you probably travel by each of the following?  
(note: US average + 10,000 miles).....  ,000 miles by car, truck, or van  
 ,000 miles by motorcycle
29. On a typical day how do you usually travel? (*check one only*)  
1  Walk  
2  bicycle  
3  motorcycle  
4  truck or van  
5  subcompact or compact car  
6  mid-size or full-size car  
7  bus, subway, or train
30. What percent of the time do you usually buckle your safety belt when driving or riding? .....  %
31. On the average, how close to the speed limit do you usually drive?.....  
1  within 5 mph of limit  
2  6-10 mph over limit  
3  11-15 mph over limit  
4  more than 15 mph over limit
32. How many times in the last month did you drive or ride when the driver had perhaps too much to drink?.....  times last month

33. How many drinks of alcoholic beverages do you have in a typical week? (*write the number of each type you drink*).....
- bottles or cans of beer  
   glasses of wine  
   wine coolers  
   mixed drinks or shots of liquor

**(MEN GO ON TO QUESTION 40)**

34. At what age did you have your first menstrual period?.....   years old
35. How old were you when your first child was born? (*if no children write 0*).....   years old
36. How long has it been since your last breast x-ray? (mammogram).....
- 1  less than 1 year ago  
2  1 year ago  
3  2 years ago  
4  3 or more years ago  
5  never
37. How many women in your natural family (mother or sisters only) have had breast cancer?.....   women
38. Have you had a hysterectomy operation?.....
- 1  yes  
2  no  
3  not sure
39. How long has it been since you had a Pap smear test?.....
- 1  less than 1 year ago  
2  1 year ago  
3  2 years ago  
4  3 or more years ago

**(WOMEN GO TO QUESTION 41)**

40. How long has it been since you had a rectal or prostate exam?.....
- 1  less than 1 year ago  
2  1 year ago  
3  2 years ago  
4  3 or more years ago  
5  never
41. In an average week, how many times do you engage in physical activity? (exercise or work which lasts at least 20 minutes without stopping and which is hard enough to make you breathe heavier and your heart beat faster).....
- 1  less than 1 time per week  
2  1 or 2 times per week  
3  at least 3 times per week
42. Do you eat foods every day that are high in cholesterol or fat, such as fatty meat, cheese, fried foods or eggs?.....
- 1  yes  
2  no
43. In general, how satisfied are you with your life?.....
- 1  mostly satisfied  
2  partly satisfied  
3  not satisfied
44. Have you suffered a personal loss or misfortune in the past year that had a serious impact on your life? (for example, a job loss, disability, separation, jail term, death of someone close to you)...
- 1  yes, 1 loss  
2  yes, 2 or more losses  
3  no losses

45. In general would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

46. Compared to one year ago, how would you rate your health in general now?

- Much better than one year ago
- Somewhat better now than one year ago
- About the same
- Somewhat worse now than one year ago
- Much worse now than one year ago

**The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

	<u>Yes,</u> <u>Limited</u> <u>a Lot</u>	<u>Yes,</u> <u>Limited a</u> <u>Little</u>	<u>No, Not</u> <u>Limited</u> <u>at All</u>
47. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. Bending, kneeling, or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>53. Walking more than a mile</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>54. Walking more than a mile</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. Walking several blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. Walking one block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. Bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

	<u>Yes</u>	<u>No</u>
58. Cut down the amount of time you spend on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
59. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
60. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
61. Had difficulty performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/>	<input type="checkbox"/>

**During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

	<u>Yes</u>	<u>No</u>
62. Cut down the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
63. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
64. Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>



77. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

How TRUE or FALSE is each of the following statements of you?

	<u>Definitely True</u>	<u>Mostly True</u>	<u>Don't Know</u>	<u>Mostly False</u>	<u>Definitely False</u>
78. I seem to get sick a little easier than other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
79. I am as healthy as anybody I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
80. I expect my health to get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
81. My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

***FOR OFFICE USE ONLY***

Date Reviewed: \_\_\_\_\_

Reviewer's Name: \_\_\_\_\_

Additional Assessment needed:

- Lab: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_
- X-ray: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_
- Wellness Visit \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_
- Other: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Recommendation for Health Assessment:

- Completed Date: \_\_\_\_\_
- PPB only Date: \_\_\_\_\_ Time: \_\_\_\_\_ Provider: \_\_\_\_\_
- Extended Date: \_\_\_\_\_ Time: \_\_\_\_\_ Provider: \_\_\_\_\_

Results:

Date: \_\_\_\_\_ Given by: \_\_\_\_\_

- To Patient  By Phone  By Mail