Health Risk Assessment

***AWV** Annual Wellness Visit*

Derry Medical Center

Derry • Londonderry • Windham

Please complete this form prior to your visit and bring this with you to your Annual Wellness Visit appointment.

Your Name: _____

Your date of birth: _____ Today's Date: _____

Your answers to the following questions will help us provide high quality health care. Please complete this form as well as you can and the nurse will collect it during your visit.

General Health

1. **During the past four weeks,** in general, how would you rate your health?

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

2. **During the past four weeks**, how have things been going for you?

   - ☐ Very bad; could hardly be worse
   - ☐ Pretty bad
   - ☐ Good and bad parts about equal
   - ☐ Pretty well
   - ☐ Very well; could hardly be better

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3. **During the past four weeks**, how often have you had trouble sleeping well?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Seldom
- ☐ Never

4. **During the past four weeks**, how often have you had trouble with your teeth or dentures?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Seldom
- ☐ Never

5. **During the past four weeks**, how often have you had trouble eating well?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Seldom
- ☐ Never

6. **During the past four weeks**, how much bodily pain have you generally had?

- ☐ Severe pain
- ☐ Moderate pain
- ☐ Mild pain
- ☐ Very mild pain
- ☐ No pain

7. **During the past four weeks**, how often have you had sexual problems?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Seldom
- ☐ Never

Self-Management and Support

8. How often do you have trouble taking medications the way you have been told to take them?

- ☐ I seldom take them as prescribed
- ☐ I sometimes take them as prescribed
- ☐ I usually take them as prescribed
- ☐ I always take them as prescribed
- ☐ Do not have to take medicine

9. How confident are you that you can control and manage most of your health problems?

- ☐ Not very confident
- ☐ Somewhat confident
- ☐ Very confident
- ☐ Do not have any health problems

10. **During the past four weeks**, was someone available to help you if you needed and wanted help?

    (For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with your daily chores; or needed help just taking care of yourself.)

    - ☐ No, not at all
    - ☐ Yes, a little
    - ☐ Yes, some
    - ☐ Yes, quite a bit
    - ☐ Yes, as much as I wanted

Physical Activity

11. **During the past four weeks**, what was the hardest physical activity you could do for at least two minutes?

    - ☐ Very light
    - ☐ Light
    - ☐ Moderate
    - ☐ Heavy
    - ☐ Very heavy

12. Do you exercise for about 20 minutes three or more days a week?

    - ☐ No, I usually do not exercise this much
    - ☐ Yes, some of the time
    - ☐ Yes, most of the time

Safety

13. Do you always fasten your seat belt when you are in a car?

- ☐ No
- ☐ Yes, sometimes
- ☐ Yes, usually
- ☐ Yes, always

14. **During the past four weeks,** have you fallen or felt dizzy when standing up?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Seldom
- ☐ Never

15. **In the past year**, have you fallen two or more times?

- ☐ Yes
- ☐ No

16. Are you afraid of falling?

- ☐ Yes
- ☐ No

Accessibility

17. Can you get to places that are farther than walking distance without help?

(For example, can you travel alone or on buses or taxis, or drive your own car?)

- ☐ No
- ☐ Yes

18. Are you having difficulties driving your car?

- ☐ Yes, often
- ☐ Sometimes
- ☐ No
- ☐ I do not use a car

Activities of Daily Living

19. Can you go shopping for groceries or clothes without someone's help?

- ☐ No
- ☐ Yes

20. Can you prepare your own meals?

- ☐ No
- ☐ Yes

21. Can you do your housework without help?

- ☐ No
- ☐ Yes

22. Can you handle your own money without help?

- ☐ No
- ☐ Yes

Social and Behavioral Health

23. Are you a smoker?

- ☐ Yes, and I might quit
- ☐ Yes, but I'm not ready to quit
- ☐ No

24. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- ☐ 10 or more drinks per week
- ☐ 6 – 9 drinks per week
- ☐ 2 – 5 drinks per week
- ☐ One drink or less per week
- ☐ No alcohol at all

25. **During the past four weeks**, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

- ☐ Extremely
- ☐ Quite a bit
- ☐ Moderately
- ☐ Slightly
- ☐ Not at All

26. During the **past four weeks**, how much have you been bothered by feeling anxious, depressed, irritable, sad, or downhearted and blue?

- ☐ Extremely
- ☐ Quite a bit
- ☐ Moderately
- ☐ Slightly
- ☐ Not at All

Independence

For each area of functioning listed below, please check the **one** statement that most accurately describes you. The word "assistance" means supervision or direction.

		For Office Use Only
Bathing		
☐ I need help getting in or out of the tub or require total bathing	(0)	
☐ I need help with bathing more than one part of the body	(0)	
☐ I need help in bathing only a single part of body (such as back)	(1)	
☐ I can bath myself completely independently	(1)	
Dressing		
☐ I need help with getting dressed or need to be completely dressed	(0)	
☐ I get clothes from the closet and can put them on without assistance (This does not include any help I require to tie my shoes)	(1)	
Toileting		
☐ I need help getting on the toilet, cleaning myself, or use a bedpan	(0)	
☐ I get on and off the toilet and clean genital area without help	(1)	
Transfer		
☐ I need help moving from bed to chair that requires complete assistance	(0)	
☐ I move in and out of bed or chair without or with minimal assistance from a personal aide	(1)	
Continence		
☐ I am partially incontinent or totally incontinent	(0)	
☐ I exercise complete self-control over urination and defecation	(1)	
Feeding		
☐ I need partial or total help with feeding	(0)	
☐ I can get food from plate into mouth without any help	(1)	
	Total: *(0-6)*	☐

Thank you for completing. Please give this form to the nurse.