**WESTERN VALLEY FAMILY PRACTICE, P.C.**

**REDLANDS AFTER HOURS**

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Health Risk Assessment

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* No pain
* Mild pain
* Moderate pain
* Severe pain

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

* Yes, as much as I wanted
* Yes, some
* No, not at all

1. Can get you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?

* Yes
* No

1. Can you go shopping for groceries or clothes without someone’s help?

* Yes
* No

1. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, getting around the house, housework?

* Yes
* No

1. Can you handle your own money without help?

* Yes
* No

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

* Excellent
* Very good
* Good
* Fair
* Poor

1. Are you having difficulties driving your car?

* Yes, often
* Sometimes
* No
* Not applicable, I do not use a car

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

* Yes
* No

1. How often during the past four weeks have you been bothered by any of the following problems?

(Circle one)

1=Never, 2=Seldom, 3=Sometimes, 4=Often, 5=Always

Falling or dizzy when standing up 1 2 3 4 5

Sexual problems 1 2 3 4 5

Trouble eating well 1 2 3 4 5

Teeth or denture problems 1 2 3 4 5

Problems using the telephone 1 2 3 4 5

Tiredness or fatigue 1 2 3 4 5

1. Have you fallen two or more times in the past year?

* Yes
* No

1. Are you a smoker?

* No
* Yes, and I am ready to quit
* Yes, but I’m not ready to quit

1. 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 or more drinks per week
* One drink or less per week
* No alcohol at all

1. Do you exercise for about 20 minutes three or more days per week?

* Yes
* No

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

* I always take them as prescribed
* I seldom take them as prescribed
* Sometimes I take them as prescribed
* I do not have to take medicine

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

* Very confident
* Somewhat confident
* Not very confident
* I do not have any health problems

1. In the past 7 days, how many servings of fruit and vegetables did you typically eat each day? (1 serving=1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup=size of a baseball.)

\_\_\_\_\_\_\_\_\_\_\_\_\_ servings per day.

1. In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day? (1 serving=1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.) \_\_\_\_\_\_\_\_\_\_\_servings per day.
2. In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (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.
3. In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

* Almost all the time
* Most of the time
* Some of the time
* Almost never

1. In the past 2 weeks, how often were you able to stop worrying or control your worrying?

* Almost all of the time
* Most of the time
* Some of the time
* Almost never

1. How often is stress a problem for you in handling such things as: Your health, finances, family or social relationships and/or work?

* Never or rarely
* Sometimes
* Often
* Always

1. How often do you get the social and emotional support you need?

* Always
* Sometimes
* Rarely
* Never

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

Biometric Measures-Self Reported

(Please fill in below questions if the following items have not been recorded by the office in the last year)

Blood Pressure

1. 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

Cholesterol

1. 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 / sure

Blood Glucose

1. If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?

* Desirable (below 100)
* Borderline high (100-125)
* High (125 or higher)
* Don’t know / not sure

1. If diabetic, and you have had your hemoglobin A1c level checked in 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

Overweight / Obesity

1. What if your height without shoes? (for example, 5 feet and 6 inches=5’6’’)\_\_\_\_\_\_\_\_ft\_\_\_\_\_\_\_\_inches
2. What is your weight? (weight in pounds)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or medical assistant.**