ThoroughCare Health Risk Assessment

This Questionnaire is an important part of your FREE Annual Wellness Visit from Medicare.
Please answer these questions to the best of your knowledge. These answers will help your provider during their review.
Everything you answer here is completely confidential. If you have any questions, let us know!

Patient Name: _____

Today's Date: _____ / _____ / _____

My Provider / Doctor's Name: _____

1. Please check any medical problems or conditions that YOU have now or had in the past.

Alzheimer's Disease/dementia	☐	Emphysema/lung disease	☐	Macular Degeneration	☐
Anemia	☐	Enlarged prostate	☐	Obesity	☐
Arthritis	☐	Gallbladder disease	☐	Osteoporosis	☐
Asthma/wheezing	☐	Glaucoma	☐	Parkinson's Disease	☐
Bladder/kidney problems	☐	Gout	☐	Pneumonia	☐
Blood clots	☐	Heart attack	☐	Rheumatic fever	☐
Bowel problems	☐	Heart disease	☐	Rheumatoid Arthritis	☐
Cancer	☐	Heart murmur	☐	Sexual problems	☐
Cataracts	☐	Hiatal hernia/esophageal stricture/GERD	☐	Skin problems	☐
Colon Polyp	☐	High cholesterol	☐	Stomach problems	☐
Congestive Heart Failure	☐	High blood pressure	☐	Stroke	☐
Depression	☐	Incontinence (urinary or stool leakage)	☐	Thyroid disease	☐
Diabetes (Type 1)	☐	Liver Disease	☐	Transfusions (blood or products)	☐
Diabetes (Type 2)	☐	Low Back Pain (chronic)	☐	Tuberculosis	☐

☐ Other Conditions _____ I don't have any of these ☐

2. Please check any medical problems or conditions that YOUR FAMILY has/had?

	My Mother	My Father	My Brother(s)	My Sister(s)	My Children
Abdominal Aortic Aneurysm (AAA)	☐	☐	☐	☐	☐
Alzheimer's disease/dementia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Blood clots	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐
Ovarian cancer	☐	☐	☐	☐	☐
Prostate cancer	☐	☐	☐	☐	☐
Uterine cancer	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Heart Disease (CAD)	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Kidney Failure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Other Conditions	☐	☐	☐	☐	☐

3. List any Surgeries that you may have had (Include approx date and reason)

4. List any hospital stays you've had other than surgeries? (list reason and length of stay)

5. List any other doctors you see on a regular basis (other than our office).

6. List any healthcare supplies you receive on a regular basis. (Ex: oxygen, diabetic supplies)

7. Please list all prescription medications, dietary or herbal supplements or over-the-counter medicines that you take regularly or as needed? (Please list dosage and frequency of each)

8. Do you have any allergies to medicines, latex or X-ray dyes?

9. Alcoholic Beverages

Do you drink any alcoholic beverages? Yes ☐ No ☐

Have you ever felt you should cut down on your drinking? Yes ☐ No ☐

Have people annoyed you by criticizing your drinking? Yes ☐ No ☐

Have you ever felt bad or guilty about your drinking? Yes ☐ No ☐

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? Yes ☐ No ☐

How many alcoholic beverages do you drink, on average, per week?

- None ☐
- Less than 1 ☐
- one - seven ☐
- eight - fourteen ☐
- More than 14 ☐

10. Tobacco Use

Do you currently smoke cigarettes? Yes (currently) ☐ No (not now) ☐ No, but I smoked in the past ☐

<u>Currently (if you use tobacco now)</u>

How many years have you smoked? (enter # of years) _____ years

How many packs of cigarettes do you smoke per day? _____ packs

Do you use any other type of tobacco product? Yes ☐ No ☐

<u>If you smoked in the past</u>

How many years ago did you quit? _____ years ago

How many years did you smoke? _____ years ago

How many packs did you smoke per day? _____ packs

11. Drug use

Do you use any illegal drugs? Yes ☐ No ☐

What drug(s) are you using?

Do you use any prescription drugs other than as directed by your doctor? Yes ☐ No ☐

What prescription drug(s) are you taking other than as directed?

12. Depression

	Not at all	Several Days	More than 1/2 the days	Nearly Every Day
Over the past 2 weeks, how often have you felt down, depressed or hopeless?	☐	☐	☐	☐
Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?	☐	☐	☐	☐
In the past 2 weeks, how often have you felt nervous, anxious or on edge?	☐	☐	☐	☐
In the past 2 weeks, how often were you not able to stop worrying or control your worrying?	☐	☐	☐	☐

Have your feelings caused you distress or interfered with your ability to get along socially with family or friends? Yes ☐ No ☐

How often is stress a problem for you in handling such things as your health, your finances, your family or social relationships or your work?

Never or Rarely ☐ Sometimes ☐ Often ☐ Always ☐

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

Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐

13. Health Habits, Diet and Exercise

In general, would you say your health is

Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

How would you describe the condition of your mouth and teeth - including false teeth or dentures?

Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

How many days per week , on average, do you eat a healthy, balanced diet? (To see what a healthy diet contains, click the green ?)

1 - 2 days ☐ 3 - 4 days ☐ 5 - 6 days ☐ 7 days ☐ Never ☐

Do you exercise at least 3 days per week? Yes ☐ No ☐ Usually ☐

What type of exercise do you do? _____

During the past 4 weeks, how much bodily pain have you had on average?

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

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

In the past 7 days, how often have you felt sleepy during the daytime?

Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐

Do you always wear a seat belt when you are in a car? Yes ☐ No ☐

Do you protect yourself from the sun when outside? (hat, sunscreen, etc) Yes ☐ No ☐

14. Hearing

Do you have hearing aids?	Yes, Left Ear	☐	Yes, Right Ear	☐	Yes, both Ears	☐	No ☐
Do you have any difficulty hearing?	Yes	☐	Sometimes	☐	No	☐	

15. Activites of Daily Living / Independent Living

Do you need help (or already get help) with any of these activities?	I don't need help with this	I currently get help with this	I could use help with this
Dressing yourself for the day	☐	☐	☐
Eating your meals	☐	☐	☐
Walking across the room (with cane or walker)	☐	☐	☐
Bathing or showering (washing your body)	☐	☐	☐
Grooming yourself: Combing your hair, brushing your teeth, etc	☐	☐	☐
Getting to and using the toilet in time	☐	☐	☐
Using the telephone	☐	☐	☐
Taking your medicines as directed and on time	☐	☐	☐
Preparing your meals	☐	☐	☐
Managing your money (keeping track of expenses, paying bills)	☐	☐	☐
Moderately heavy housework (laundry, washing floors or windows)	☐	☐	☐
Shopping for personal items (toiletries, medicine) or groceries	☐	☐	☐
Driving a car or being able to take public transportation (bus)	☐	☐	☐

16. History of Falls / Home Safety

Have you fallen in the past year?	Yes ☐	No ☐	N/A ☐
Do you feel unsteady when standing or walking?	Yes ☐	No ☐	N/A ☐
Do you worry about falling?	Yes ☐	No ☐	N/A ☐
Are the walkways in your home clear of cords, furniture, clutter?	Yes ☐	No ☐	N/A ☐
Are your stairways safe? (railings on each side, no loose boards or carpet)	Yes ☐	No ☐	N/A ☐
Have you removed any throw rugs in the home?	Yes ☐	No ☐	N/A ☐
Do you have grab bars in the bathroom near the shower and toilet?	Yes ☐	No ☐	N/A ☐
Are all rooms well lit, including the path from the bedroom to bathroom?	Yes ☐	No ☐	N/A ☐
Do you have working smoke detectors in your home and change the batteries?	Yes ☐	No ☐	N/A ☐

17. Have you had the following tests/vaccines/screenings?	Yes, and I know the exact date Enter Date	Yes, but UNSURE of exact date	No (Or Unsure)
Influenza Vaccine (flu shot) in the last year	☐ ____/____/____	☐	☐
PCV13 Pneumoccal shot (Ever)	☐ ____/____/____	☐	☐
PPSV23 Pneumococcal shot after age 65	☐ ____/____/____	☐	☐
Herpes Zoster Vaccine (Shingles) at or after age 60	☐ ____/____/____	☐	☐
Tetanus booster (Td) in the past 10 years	☐ ____/____/____	☐	☐
Hepatitis B Virus (HBV) vaccine (3 scheduled dosages: 0, 1 and 6 months)	☐ ____/____/____	☐	☐
Colorectal Cancer Screening Fecal Occult Blood Test (FOBT) in the last year	☐ ____/____/____	☐	☐
Colorectal Cancer Screening:			
Cologuard Multitarget Stool DNA Test in the last 3 years	☐ ____/____/____	☐	☐
Colorectal Cancer Screening Flexible Sigmoidoscopy in the last 5 years	☐ ____/____/____	☐	☐
Colorectal Cancer Screening Colonoscopy in the last 10 years	☐ ____/____/____	☐	☐
Cardiovascular Screening: Lipid panel in the last 4 - 6 years	☐ ____/____/____	☐	☐
Diabetes Screening in the last 1 - 3 years	☐ ____/____/____	☐	☐
Glaucoma Screening in the last 6 months - 3 years	☐ ____/____/____	☐	☐
Bone Density Scan in the last 2 years	☐ ____/____/____	☐	☐
HIV Screening in the last 1 - 5 years	☐ ____/____/____	☐	☐
AAA Screening - Ultrasound (Ever)	☐ ____/____/____	☐	☐
Prostate Cancer Screening in the last year	☐ ____/____/____	☐	☐
Screening Mammography in the last 1 - 2 years	☐ ____/____/____	☐	☐
Cervical Cancer Screening in the last 1 - 5 years	☐ ____/____/____	☐	☐