



Health Risk Assessment

Patient Information

First name: _____ Highest grade of education completed:

Last name: _____ Less than 9th grade Some college or higher

What is the primary language spoken in your home: Some high school Don't know/not sure

English Spanish other High school graduate

Personal Health History

CHOLESTEROL

1. Do you have high cholesterol? Yes No Don't know/not sure

▶ **If yes**, do you take medication to lower your cholesterol?..... Yes No Don't know/not sure

▶ **If yes**, during the past 7 days, on how many days did you take prescribed medication to lower your cholesterol? No-could not obtain medication

_____ days None Don't know/not sure

DIABETES

2. Do you have diabetes? (Either Type 1 or Type 2) Yes No

▶ **If yes**, do you take medication to lower your blood sugar (for diabetes)?.. Yes No Don't know/not sure

▶ **If yes**, during the past 7 days, on how many days did you take prescribed medication to lower your blood sugar (for diabetes)?..... No-could not obtain medication

_____ days None Don't know/not sure

BLOOD PRESSURE

3. Do you have hypertension (high blood pressure)? Yes No Don't know/not sure

▶ **If yes**, do you take medication to lower your blood pressure?..... Yes No Don't know/not sure

▶ **If yes**, during the past 7 days, on how many days did you take prescribed medication (including diuretic/water pills) to lower your blood pressure?..... No-could not obtain medication

_____ days None Don't know/not sure

4. Do you measure your blood pressure at home or using other calibrated sources? (Select all that apply.) Yes No-I was never told to

No-I don't know how to measure

No-I do not have the equipment to measure my blood pressure

Don't know/not sure/other

▶ **If yes**, how often do you measure your blood pressure at home or using other calibrated sources?..... Multiple times per day

Daily A few times per week

Weekly Monthly

Don't know/not sure/other

▶ **If yes**, do you regularly share blood pressure readings with a healthcare provider for feedback?..... Yes No Don't know/not sure

GENERAL

5. Have you been diagnosed by a healthcare provider as having any of these conditions: coronary heart disease/chest pain, heart attack, heart failure, stroke/transient ischemic attack (TIA), vascular disease, or congenital heart defects?..... Yes No Don't know/not sure

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For office use only

Assessment date: _____ Provider name: _____ Patient ID#: _____

Patient name: _____

DIET AND EXERCISE	6. How much fruit do you eat in an average day? (1 cup = 1 small apple)	_____ cups <input type="checkbox"/> None
	7. How many vegetables do you eat in an average day? (1 cup = 1 ear corn)	_____ cups <input type="checkbox"/> None
	8. Do you eat two servings or more of fish weekly? (1 serving = 7 ounce can tuna or 8 oz of Salmon steak)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	9. Do you eat 3 ounces or more of whole grains daily? (1 serving = 1 ounce, a serving equals 1 slice whole wheat bread, 1/2 cup oatmeal)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	10. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly? (Three cans regular soda, juice)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	11. Are you currently watching or reducing your sodium or salt intake ?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	12. How much moderate physical activity do you get in a week? (Walking able to talk/hold conversation, general gardening).....	_____ minutes <input type="checkbox"/> None
	13. How much vigorous physical activity do you get in a week? (Running not able to talk/hold conversation, aerobic dance)	_____ minutes <input type="checkbox"/> None

SMOKING STATUS	14. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form).....	<input type="checkbox"/> Never smoked <input type="checkbox"/> Current smoker <input type="checkbox"/> Quit (1-12 months ago) <input type="checkbox"/> Quit (more than 12 months ago)
	15. About how many hours a day, on average, are you in the same room or vehicle with another person who is smoking?.....	_____ hours <input type="checkbox"/> less than one hour <input type="checkbox"/> None

PHYSICAL/ MENTAL HEALTH	16. Thinking about your physical health , which includes physical illness and injury, on how many of the past 30 days was your physical health not good?..	_____ days <input type="checkbox"/> Don't know/not sure
	17. Thinking about your mental health , which includes stress, depression, and problems with emotions, on how many of the past 30 days was your mental health not good?.....	_____ days <input type="checkbox"/> Don't know/not sure
	18. During the past 30 days, on about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation?	_____ days <input type="checkbox"/> Don't know/not sure

FAMILY HEALTH HISTORY	19. How many close blood relatives have had a stroke or heart attack? ▶ Father, brothers, or sons (before age 50).....	_____ relatives <input type="checkbox"/> None <input type="checkbox"/> Don't know/not sure
	▶ Mother, sisters or daughters (before age 60)	_____ relatives <input type="checkbox"/> None <input type="checkbox"/> Don't know/not sure
	20. How many close blood relatives (parents, brothers, sisters, sons or daughters) have been diagnosed by a healthcare professional with: ▶ High blood pressure (either number above 140/90) or put on blood pressure lowering medication at age 50 or younger?.....	_____ relatives <input type="checkbox"/> None <input type="checkbox"/> Don't know/not sure
	▶ Diabetes (either Type 1 or Type 2)?	_____ relatives <input type="checkbox"/> None <input type="checkbox"/> Don't know/not sure