Roundup Memorial
Healthcare

AWV - HEALTH RISK ASSESSMENT FORM

Name: _____

Date: _____

Please complete this questionnaire before seeing your Healthcare Provider and bring it to your Annual Wellness Visit (AWV) appointment. Thank You!

PHYSICAL ACTIVITY

1. In the past 7 days, how many days did you exercise? _____days
2. On days when you exercised, for how long did you exercise (in minutes)?
   _____ minutes per day

3. How intense was your exercise?
   _____ Light (like stretching or slow walking)
   _____ Moderate (like brisk walking)
   _____ Heavy (like jogging or swimming)
   _____ Very heavy (like fast running or stair climbing)
   _____ I am currently not exercising

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TOBACCO USE

1. In the last 30 days, have you used tobacco?

   Smoked: _____ Yes _____ No

   Used a smokeless tobacco product: _____ Yes _____ No

   If Yes-to either, would you be interested in quitting tobacco use within the next month
   _____ Yes _____ No

   How many years have you smoked _____ (Number of Years)

   Quit Smoking _____ (When)?

ALCOHOL USE

1. In the past **4 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

2. Do you ever drive after drinking, or ride with a driver who has been drinking?

   _____ Yes _____ No

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NUTRITION

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

2. 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% of 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)

3. In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples: fried chicken, fried fish, bacon, French fries, potato chips, doughnuts, and foods made with whole milk, cream, cheese or mayonnaise).

   _____ (servings per day)

4. In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day? _____ (sugar-sweetened beverages consumed per day)

VEHICLE USE

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

2. Are you having difficulties driving your car? _____ Yes, often
   _____ Sometimes
   _____ No
   _____ I don't drive

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DEPRESSION

1. In the past **2 weeks**, how often have you felt down, depressed or hopeless?

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

2. In the past **2 weeks,** how often have you felt little interest or pleasure in doing things?

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

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

ANXIETY

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

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

2. In the past **2 weeks**, how often were you not able to stop worrying or control worrying?

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

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

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

FALLS

1. Have you fallen two or more times in the past year? _____ Yes _____ No
2. Are you afraid of falling? _____ Yes _____ No

SLEEP

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

_____ Always
_____ Usually
_____ Sometimes
_____ Rarely
_____ Never

FAMILY HISTORY

Family History	Self	Father	Mother	Sister	Brother	Aunts	Uncles	Daughters	Son
Deceased									
High Blood Pressure									
Heart Disease									
Stroke									
Kidney Disease									
Obesity									
Genetic Disorder									
Alcoholism									
Liver Disease									
Depression or other Psychiatric Disorder									
Colon/Rectal Cancer									
Breast Cancer									
Other Cancer									
Other:									

Thank you for completing this questionnaire.

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