Health Risk & Preventive Care Assessment

Allied Pacific IPA

Member Name: _____ Member ID: _____

Date of Birth: _____Date of Service: _____

I feel my overall health condition is ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please circle "True" or "False" as the preceding statement pertains to you and speak with your doctor if you have any questions.

Diet			
1.	I eat three balanced meals a day that includes fruits, vegetables, grains and calcium rich foods.	True	False
2.	I limit eating fried or fast foods.	True	False
3.	I seldom drink soda, juice drink, sports or energy drink.	True	False
4.	I have gained or lost over 10 lbs. in the last 6 months.	True	False
Physical Activity			
5.	I exercise.	True	False
	If you answered "True" to question 5, please answer the following questions a, b, and c: **a.** How many days a week do you exercise? ☐ 1 to 2 days ☐ 3 to 4 days ☐ 5 to 7 days **b.** How long do you exercise? ☐ <30 Mins ☐ >30 Mins ☐ 1 hour ☐ ≥ 1 hr **c.** What do you do for exercise? ☐ Walking ☐ Jogging ☐ Tai-Chi ☐ Swimming ☐ Gardening ☐ Other _____		
Continence			
6.	I have problems with urinating.	True	False
	If you answered "True" to question 6, why do you have trouble with urinating? ☐ Leaking ☐ Frequent trips ☐ Other_____		
7.	I can exercise self-control over urination and defecation.	True	False
8.	I have frequent urinary tract infections (more than 2 times a year).	True	False
9.	I have been diagnosed with an enlarged prostate.	True	False
Home & Safety			
10.	I feel safe where I live.	True	False
11.	I have experienced physical violence such as being hit or kicked.	True	False
12.	I own a gun.	True	False
	If you answered "True" to question 12, do you keep your gun in a safe place?	Yes	No
13.	I drive cautiously, always wear a seat belt while sitting in a car, and have not had a car accident in the past year.	True	False
Fall Risk, Vision & Hearing Problems			
14.	I have fallen in the past 12 months.	True	False
	If you answered "True" to statement 14, please answer the following questions a, b, and c: **a**. How many times did you fall? ☐ 1 time ☐ 2 or more times		

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	b. Did your fall cause a fracture or serious injury? ☐ Yes. Explain the injury: _____ ☐ No **c**. Reason(s) for your fall: ☐ Fainted ☐ Dizziness ☐ Difficulty walking ☐ Weak muscle ☐ Poor vision ☐ Lost Balance ☐ Tripped ☐ Other reason(s) _____		
15.	I have safety bars installed in my bathroom.	True	False
16.	My vision and hearing changed a lot in the past 12 months.	True	False
	Oral Health and Lifestyle		
17.	I have problems with my oral health.	True	False
	If you answered "True" to statement 17, why? ☐ Cavities ☐ Periodontal Disease ☐ Dentures ☐ Other _____		
18.	I can chew and swallow easily.	True	False
19.	I have problems sleeping at night. I get _____ hours of sleep a day.	True	False
20.	I take drugs or medicines to help me sleep, feel better, or lose weight.	True	False
21.	I have smoked/chewed tobacco.	True	False
	If you answered "True" to statement 21, please answer the following questions a and b: **a.** ☐ I smoke. I have smoked since I was _____ years old. _____ **b.** ☐ I smoked but quit in ____ , ____ (month, year).		
22.	There are smokers in my home.	True	False
23.	I drink alcohol.	True	False
	If you answered "True" to question 23, how many glasses do you drink a day? ☐ < 2 glasses ☐ > 2 glasses		
24.	My partner and/or I have sexually transmitted disease(s).	True	False
25.	My partner and/or I have more than one sex partner	True	False
26.	My partner and I always use a condom when we have sex.	True	False
27.	I have been forced to have sex.	True	False
	Functional Status Assessment		
28.	I can take care of my daily living activities such as eating, toileting, bathing, dressing, walking, etc. If you answered "False", why? _____	True	False
29.	I can handle jobs like doing laundry, cooking, paying bills, using the telephone, driving or taking buses, shopping, etc. If you answered "False", why? _____	True	False
30.	I have trouble remembering important things such as taking my medications on	True	False

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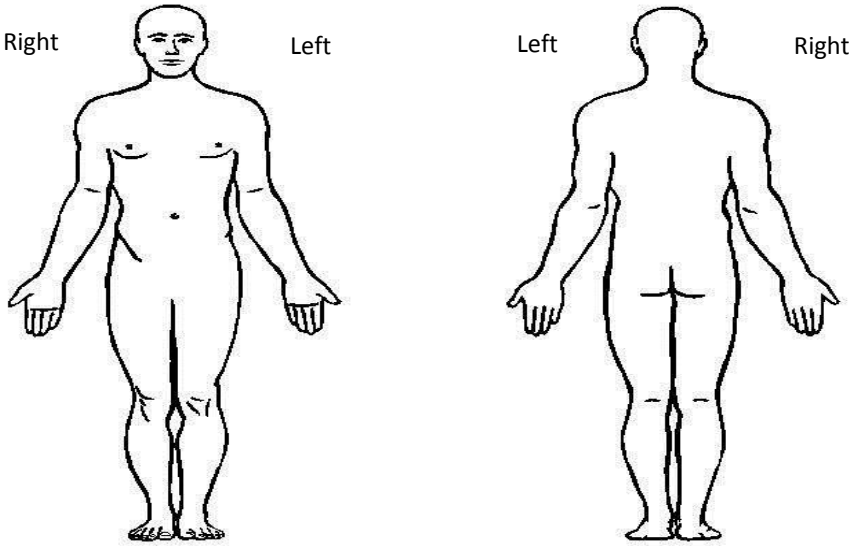
	time.		
Chronic Pain Assessment			
31.	I have chronic pain.	True	False

If you answered "True" to question 31, please answer the following questions a-e:

a. Please mark where it hurts on your body on the diagram.

☐ Head
☐ Neck/Shoulder
☐ Hand/Arm
☐ Chest
☐ Back
☐ Abdomen
☐ Legs/Thighs
☐ Other
_____



b. Intensity: ☐ Mild (1-3) ☐ Moderate (4-6) ☐ Severe (7-10)

c. Frequency: ☐ Rarely ☐ Frequently ☐ Daily

d. For how long have you experienced this pain? Years _____ Months _____

e. Describe your pain.

☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Other _____

Cancer Screenings			
32.	Have you had a colonoscopy in the past 10 years? If yes, when and where? Month/Year _____ Facility_____	Yes	No
33.	For females, have you had a mammogram in the past 2 years? If yes, when and where? Month/Year _____ Facility_____	Yes	No

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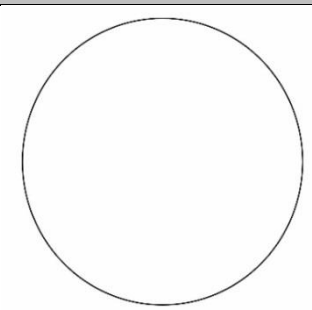
34.	**Cognitive Assessment**		
Please arrange the hours 1-12 on the circle to create a clock and draw the hands to 11:10 in the box.			

Family and Friends Support			
35.	If needed, I have someone to take care of my daily living.	True	False
36.	I have someone to help me make decisions about my health and medical care. Name: _____Phone: _____	True	False
37.	I have someone to call when I need help in an emergency. Name: _____Phone: _____	True	False
Advanced Directive			
38.	Have you ever completed an Advanced Care Plan?	Yes	No
	If you marked "No", do you want to receive one? *Please ask your PCP for materials	Yes	No

Primary Care Physicians (PCP) Printed Name: _____ Title: M.D. / D.O.

*PCP's Signature:	**Member's Signature:	Date:

*** I have reviewed this questionnaire with my patient and will schedule a follow up as needed.**

*** I understood the above questionnaire and received education and counseling from my Primary Care Physician.**

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Depression Screening (PHQ-9)					
Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several Days	More Than Half the Days	Nearly Everyday
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed or being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
1-4 Minimal Depression, 5-9 Mild Depression, 10-14 Moderate Depression, 15-19 Moderately Severe Depression, 20-27 Severe Depression		**TOTAL:**			

10	If you circle any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	☐
		Somewhat difficult	☐
		Very difficult	☐
		Extremely difficult	☐

Doctor Name: _____ Doctor Signature: _____ Date: _____

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