TUMWATER family practice CLINIC

TFPC Health Risk Assessment Name: _____ DOB: _____

1 Is your demographic information correct in our system? (See attached Patient Summary)

❑ Yes ❑ No Changes: _____

2 How would you describe your health?

❑ Good _____

❑ Okay _____

❑ Bad _____

3 Over the past year would you say your quality of life is:

❑ Better than before _____

❑ Same, no change _____

❑ A little worse _____

❑ A lot worse _____

4 Do you have problems with balance, falling or feeling dizzy? ❑ No ❑ Yes (if yes answer below)

❑ Balance problems or feeling unsteady

❑ Often feel dizzy

❑ Worry that I may fall

❑ Falls (tripping or losing balance)

❑ Fainting (loss of consciousness)

5 Have you had any falls in the last year? If so please indicate how many and answer question 5a

❑ No ❑ Yes If yes, list # of falls ❑ 1 ❑ 2 ❑ 3+

5a If you had any fall(s) in the last year, did you injure yourself?

❑ No ❑ Yes, minor injury no medical help needed ❑ Yes, needed medical help

6 Do you receive any medical supplies for any of your conditions?

❑ No ❑ Yes If so, list your medical supply company: _____

7 Do you have memory problems or worry frequently about your memory?

❑ No ❑ Yes (Provider: If yes consider cognitive testing)

8 Depression Screening

8a Do you feel down, depressed or hopeless?

❑ No ❑ Yes (Provider: If yes consider further screening)

8b Do you have little interest or pleasure in doing things?

❑ No ❑ Yes (Provider: If yes consider further screening)

9 Do you have any problems leaking urine?

❑ No ❑ Yes If yes, describe problems: _____

10 Do you have any problems with your hearing?

❑ No ❑ Yes ❑ Not sure, I would like to be tested

11 Do you have problems with access to resources or need help with any of the following?

- ❑ Transportation
- ❑ Meals
- ❑ Social support (family/friends)
- ❑ Housekeeping
- ❑ Housing or affording rent/mortgage
- ❑ Financial security
- ❑ Utilities (power, water, heat)
- ❑ Mobility or safety devices (walker, cane, wheelchair, ramp, grab bars, shower chair etc.)
- ❑ Personal care giver or chore help
- ❑ Medications
- ❑ I rely on assistance for some of the above but don't need additional help and I have no problems accessing the resources I need.
- ❑ None of the above

Medications: *Please review the attached Patient Summary for accuracy. This is from your TFPC record. if you are no longer taking medications, please cross them out. If we are missing information please add to the patient summary or medication sheet on last page of packet.*

12 Are you prescribed or taking any medications?

❑ No ❑ Yes If yes, please answer all questions in this section.

13 How many medications are you prescribed or taking?

❑ 1-2 ❑ 3-5 ❑ 6 or more

14 Do you regularly take your prescribed medications?

❑ No ❑ Yes If no please tell us why: _____

15 Do you take any supplements or herbs?

❑ No ❑ Yes (If yes, please add to your medication list if they are not already listed)

16 Do you use more than one pharmacy?

❑ No ❑ Yes If yes, indicate why _____

My Pharmacies: _____

_____

_____

_____

17 Are you allergic to any medications?

❑ No ❑ Yes If yes, indicate allergies

Family, Social and Medical Histories: *Please review the attached Patient Summary for accuracy. If there are changes, please list any changes on the patient summary or on last page of packet.*

18 Do you currently smoke or use tobacco products?

❑ No ❑ Yes If yes, please mark all that apply

❑ Chew ❑ Snuff ❑ Vapor ❑ Cigarettes ❑ Pipe ❑ Other _____

19 Do you currently drink alcohol?

❑ No ❑ Yes If yes, how many drinks per day? _____

20 Do you currently use recreational drugs?

❑ No ❑ Yes If yes, what type and how often? _____

21 Do you have any of the following medical diagnoses? (Mark A column for Active, H column for History)

A	H	
❑	❑	Congestive heart failure (CHF, enlarged heart, valve problems)
❑	❑	Heart rhythm problems
❑	❑	Narrow or blocked arteries or vascular problems
❑	❑	Chronic bronchitis (COPD, emphysema)
❑	❑	Asthma
❑	❑	Diabetes
❑	❑	Renal failure or kidney disease
❑	❑	Amputation (loss of any limb including toe or portion of foot)
❑	❑	Depression, anxiety or other mental health disorder
❑	❑	Treatment for chronic pain
❑	❑	Chemical dependency, addiction, alcoholism (or worries you may have addiction)
❑	❑	Active cancer diagnosis (or medication related to cancer post-treatment)
❑	❑	Neurological disorder (MS, Parkinson's, dementia, alzheimer's etc.)
❑	❑	Ostomy, feeding tube (G-tube), catheter or drain tube
❑	❑	CHRONIC pancreatitis or CHRONIC hepatitis
❑	❑	Paralysis (total or partial)
❑	❑	Rheumatoid Arthritis
❑	❑	Other autoimmune disorder (lupus, scleroderma, etc.)
❑	❑	Macular degeneration, glaucoma or blindness
❑	❑	History of fracture over age 65 (Provider: consider bone density testing)
❑	❑	Other significant health problem(s) (please list) _____
❑	❑	_____
❑	❑	_____

❑ None of the Above

22 Please indicate if you have had the following screenings/preventive measures & list the date last done.

- ❑ Dexa Scan / osteoporosis screening / bone density test
  If Yes, When? _____
- ❑ Mammogram / breast cancer screening
  If Yes, When? _____
- ❑ Colonoscopy / colon cancer screening
  If Yes, When? _____
- ❑ Fecal occult test / colon cancer screening
  If Yes, When? _____
- ❑ Influenza vaccine (flu shot)
  If Yes, When? _____
- ❑ Pneumonia vaccine
  If Yes, When? _____
- ❑ Cholesterol screening / lipid test
  If Yes, When? _____
- ❑ Vision screening / eye exam
  If Yes, When? _____
- ❑ If you are diabetic, what is the date of your last A1C test? _____

23 If you have specialists or other medical providers you see, please list here:

Name:	Phone:	Specialty:

24 If you have a care-giver or someone who helps you with the day to day tasks, please list here:

Name:	Phone:	Relation:

25 If you have a medical Power of Attorney, please list here:

Name:	Phone:	Relation:

26 Healthcare decision planning

26a Do you have a current Advanced Directive?

❑ Yes ❑ No

26b Does your provider have a copy of your Advanced Directive?

❑ Yes ❑ No

26c Would you like more information about Advanced Directives?

❑ Yes ❑ No

27 Can you manage these activities of daily living?

Can you use the telephone?

❑ Yes ❑ No ❑ With help

Can you go shopping for groceries?

❑ Yes ❑ No ❑ With help

Can you get to places that are out of walking distance?

❑ Yes ❑ No ❑ With help

Can you prepare your own meals?

❑ Yes ❑ No ❑ With help

Can you do your own housework?

❑ Yes ❑ No ❑ With help

Can you do your own handyman work?

❑ Yes ❑ No ❑ With help

Can you do your own laundry?

❑ Yes ❑ No ❑ With help

Can you manage your own medications?

❑ Yes ❑ No ❑ With help

Can you manage your own money?

❑ Yes ❑ No ❑ With help

You are scheduled today for a Medicare IPPE or Annual Wellness Visit (AWV) which may also inclued a physical exam depending on your insurance coverage. The purpose of the IPPE or AWV is to promote ongoing wellness, review/update family, social and personal health histories, to assess specific potiential risk factors and to provide any necessary education or referrals. The time allocated for your visit does not typically allow us to focus on new issues or problems. New issues/problems will require a separate visit with your healthcare provider. If time does allow this today, there will be a separate fee which may have a balance due from you.

Print Patient Name: _____ Today's Date: _____

Patient Signature: _____

If you need to add medications, vitamins or supplements to your medication list, please do that here

Name of Medication	Dose	How often	I take this medication for:

Other updates to my history, including family, social, medical and surgical history

Any allergies not listed on my patient summary

Other:
