SENIOR HEALTH RISK ASSESSMENT/ALL PATIENTS 65 YEARS AND OLDER

Insurance companies require Health Risk Assessment forms filled out for ALL patients 65 years of age and over as a part of the yearly physical exam.

NAME: ___________________________ DOB: _____________ Date: ______________

DIET:

On an average day, how many servings of the following do you eat? Fruits____Vegetables____Dairy____Fiber_____
In an average week, how many servings of the following do you eat?
Red meat (beef/pork) _____ Chicken_____ Fish_______ Fried Foods______ Fast Food_______
What supplements do you take? Calcium_____ Vitamin D_____ Multivitamin_____ Other: _____________

EXERCISE:

Type: __________________________________ How often? ______________ How long each time: _________

ALCOHOL/TOBACCO:

How many alcoholic beverages do you consume per day? ______ **Per week?** _______ **Per weekend?**
Do you have a past history of heavier alcohol consumption? YES/NO **If yes, how much?**
Do you currently or have you previously used cigarettes, chewing tobacco, snuff electronic cigarettes, or vapor pens? YES/NO
If yes to currently, how much do you use? ________________
If yes to previously, how much did you use? ________________**When did you quit?** ______________________

SAFETY;

Do you drive: YES/NO **Do you wear a seat belt?** Always Sometimes Never
Do you ever drive after drinking or ever ride with a driver who has been drinking? YES/NO
Do you text and drive? YES/NO
Do you wear sun screen? Always Sometimes Never

SELF CARE:

Do you have problems with your vision? YES/NO **If yes, what problems are you having?** _____________________
When was your last eye doctor appointment? ______________**How often do you go?** _________
When was your last dental appointment? _______________________________
Do you have problems with your hearing? YES/NO **Do you wear hearing aids?** YES/NO

HOME:

Do you have stairs in your home? YES/NO **If yes, do you use the stairs?** YES/NO
Are there hand rails? YES/NO **Do you have grab bars in your shower?** YES/NO
Do you have trouble doing things with your hands such as buttoning, cooking, etc? YES/NO
Do you have issues with your balance? YES/NO **Have you fallen in the past year?** YES/NO
Do you feel depressed or sad? YES/NO **Do you feel anxious?** YES/NO
Do you independently manage your finances? YES/NO **If no, who manages them for you?** ________
Do you have trouble remembering things? YES/NO **Do you have a living will?** YES/NO
Have you named a Medical Power of Attorney? YES/NO **If yes, who?**___________________
Have you discussed your wishes for what happens to you if you can't communicate your needs? YES/NO

SOCIAL:

Do you live: Alone____ w/Family____ w/Friends___ Assisted Living___ Nursing home___
Do you feel safe where you live? YES/NO
Do you feel like you have enough social support? YES/NO
Do you need help with your medications, such as someone reminding you to take them? YES/NO
Do you need help managing your finances? YES/NO