Health Risk Assessment

The information you provide to us on this form helps us develop a care plan with your primary care provider (PCP) and any specialists you may be seeing and helps ensure your enrollment into PHP (HMO SNP) is easy as possible.

Name: _____

Birthdate: _____ Home Phone No: _____

Cell Phone No: _____ Email Address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Your Height: _____ Weight: _____ Last Blood Pressure Reading: _____

What was your last viral load (VL) count? VL: _____ Date: _____

Do you have any food or medication allergies?
☐ Yes ☐ No *If "yes," please list:*

_____

Do you have any other diagnosis other than HIV/AIDS?
☐ High Blood Pressure ☐ Diabetes ☐ Hepatitis C
☐ Asthma ☐ COPD ☐ Heart Failure/Enlarged Heart
☐ Obesity ☐ Kidney Dialysis ☐ Cancer
☐ Alcohol Use ☐ Depression ☐ Mental Illness
☐ Other Substance Use ☐ History of TB
☐ HIV Wasting ☐ Active HIV Opportunistic Infection
☐ Chronic Diarrhea ☐ Cognitive Impairment
☐ HIV Opportunistic Infection under Prophylaxis
☐ HIV Opportunistic Cancer in Remission

Have you ever felt you ought to cut down on your drinking and/or recreational or prescription drug use?
☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

How would you rate your overall health? (*Select one.*)
☐ Poor ☐ Fair ☐ Good ☐ Excellent

Please list your prescriptions, dosage and how often you take them: _____

_____

_____

_____

Do you have any trouble refilling your prescriptions? ☐ Yes ☐ No

Do you have access to and/or get enough food? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Do you have a stable place to live? ☐ Yes ☐ No

Any recent vision changes? ☐ Yes ☐ No

Any recent hearing changes? ☐ Yes ☐ No

Do you have difficulty getting transportation for your medical needs? ☐ Yes ☐ No

Over the past two (2) weeks, how often have you been bothered by the following problems?

Please place an "X" in the cell that represents your answer.	**Not at all**	**Several days**	**More than half of the days**	**Nearly every day**
Little interest or pleasure doing things				
Feeling down, depressed or hopeless				
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				
Stay in the house most or all of the time				

Have you had any problems with urine leakage?
☐ Yes ☐ No

Do you have unprotected sex? ☐ Yes ☐ No

Have you been treated for an STD in the last 12 months? ☐ Yes ☐ No *If "yes," which one(s)?*

_____

In the previous month, have you gone to urgent care?
☐ Yes ☐ No

Were you seen in the emergency room in the last six (6) months? ☐ Yes ☐ No

In the last 12 months, have you stayed overnight as a patient in hospital? ☐ Yes ☐ No *If "yes," which hospital?* _____

Who is your primary care provider (PCP)?

_____

Have you seen your PCP in the last six (6) months?
☐ Yes ☐ No

Do you have difficulty getting to doctor's appointments or other medical services? ☐ Yes ☐ No

Are you receiving any other services, i.e., dialysis, physical therapy, medical equipment, etc.?
☐ Yes ☐ No *If "yes," what services?*

_____

Have you had any problems with balance or walking?
☐ Yes ☐ No

Are you physically active (e.g., walking, stationary bike, treadmill, etc.)? ☐ Yes ☐ No

Have you fallen (without having been pushed) in the last three (3) months? ☐ Yes ☐ No

Do you use any of the following to get around?
☐ None ☐ Cane ☐ Walker ☐ Wheelchair
☐ Prosthetic Device ☐ Powered Vehicle (Scooter)
☐ Other: _____

What is your smoking status?
☐ Current (Every Day) ☐ Current (Some Days)
☐ Previous ☐ Never

Have you had a flu shot in the last 12 months?
☐ Yes ☐ No

Have you had a shot for pneumonia in the last five (5) years? ☐ Yes ☐ No

Have you had any problems with short-term memory? (e.g., what did you have for dinner last night?) ☐ Yes ☐ No

Have you had any problems with your long-term memory? (e.g., where were you born?)
☐ Yes ☐ No

Do you have trouble understanding instructions?
☐ Yes ☐ No

If you have pain, on a scale of 0-10, what is your pain level? (0=no pain, 10=the most pain you have ever felt): _____

Please Rate the Following Activities:

Please place an "X" in the cell that represents your answer.	**No Trouble**	**Need Some Help**	**Need Help**
Bathing			
Getting dressed			
Getting to and from the toilet			
Shopping			
Preparing meals			
Feeding yourself			
Using the telephone			
Housekeeping			
Laundry			
Managing medications			
Managing household finances			

What is the best way to communicate with you?
☐ My Phone ☐ Friend's/Relative's Phone
☐ Via USPS Mail ☐ Email ☐ Text Msg.

What is the best phone number to reach you by calling or text?

_____

What is your email address?

_____

What is the best day/time to reach you?

_____