UHS
UNION HEALTH SERVICE

# Health Risk Assessment Questionnaire

As a UHS Member, you are eligible to receive an annual visit. During this visit we will work with you to make a plan for how to stay well. This visit is for talking with your healthcare team about your medical history, your risk for certain diseases, the current state of your health and your plan for staying well. We will measure your height, weight and blood pressure. We might refer you for screenings or services outside of the appointment.

Specific elements are addressed during your visit. We request that you complete a Health Risk Assessment Questionnaire prior to your visit and bring it with you to your appointment.

## *Things to bring to your Annual Visit:*

- A list of the members on your healthcare team including any specialists.
- The names of your home health agency and medical equipment supply companies (ex. oxygen supplier).
- The names and locations of the pharmacies you use.

  Please bring a bag with all of the medicines you take including over-the-counter drugs, vitamins and supplements.

- List of immunizations not received at UHS

# Health Risk Assessment 2024

Member Name _____ Date of Birth _____

Physician Name _____ Chart # _____

Today's Date _____

**Personal Medical History**

| | | Year | | | Year | | | Year |
|---|---|---|---|---|---|---|---|---|
| ☐ | High Blood Pressure | | ☐ | Congestive Heart Failure | | ☐ | Asthma | |
| ☐ | High Blood Sugar | | ☐ | Heart Attack | | ☐ | Diabetes | |
| ☐ | High Cholesterol | | ☐ | Stroke | | ☐ | Thyroid Problem | |
| | | | ☐ | Cancer | | ☐ | | |

**General Health**

| | Never / Almost Never | Occasionally | Often | Very Often | Always/ Almost Always |
|---|---|---|---|---|---|
| I avoid the use of tobacco products (cigarettes, smokeless tobacco, cigars, and pipes) and/or limit myself to 5 drinks (beer, wine, liquor) per week. | | | | | |
| I protect my skin from sun damage by using sunscreen, wearing hats, and/or avoiding tanning booths and sunlamps. | | | | | |
| I visit my dentist every 6 months for regular checkups. | | | | | |
| I see my physician for routine check-ups, health screenings, immunizations, vaccinations and disease prevention. | | | | | |
| I am living a healthy lifestyle. | | | | | |

**Mental Wellness**

In the past 2 weeks, how often have you been bothered by the following:

| | Never / Almost Never | Occasionally | Often | Very Often | Always/ Almost Always |
|---|---|---|---|---|---|
| I am stressed over health, finances, relationships, or work. | | | | | |
| I feel that I have family and friends that I can confide in to assist in managing stress. | | | | | |
| I express my feeling of anger and frustration in ways that are not hurtful to myself or others. | | | | | |
| The level of stress in my work environment is manageable for me. | | | | | |
| I am satisfied with the balance between my work time and leisure time. | | | | | |

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**Health and Habits**

In the past week, how many days did you exercise?

How many minutes per week?

What form of exercise do you do?

☐ Walking ☐ Running ☐ Biking ☐ Swimming ☐ Yoga
☐ Weight Training
☐ Other

How do you rate you nutrition?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

I eat at least five servings of fruits and vegetables every day (one serving equals one half cup). ☐ Yes ☐ No

I eat at fast food restaurants less than three times per week. ☐ Yes ☐ No

I maintain a healthy weight within the recommendations specified by a health care professional. ☐ Yes ☐ No

Do you find yourself having trouble hearing people speak? ☐ Yes ☐ No

Do you always use your seat belt in the car? ☐ Yes ☐ No

**Function and Mobility**

How much difficulty do you have with the following activities?

| | I can do this by myself | I need some help to do it | I cannot do this; another person needs to do it for me |
|---|---|---|---|
| Preparing food and eating | | | |
| Bathing yourself | | | |
| Getting dressed | | | |
| Using the toilet | | | |
| Shopping | | | |
| Using the telephone | | | |
| Housekeeping | | | |
| Laundry | | | |
| Driving or using transportation | | | |
| Managing own finances | | | |
| Taking your own medications | | | |

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Do you use any devices? (check all that apply)

☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Devices used for dressing
☐ None of the above

In the past year, have you fallen or had a near fall? ☐ Yes ☐ No

Are you afraid of falling? ☐ Yes ☐ No

Physician Signature: _____ Date: _____