**ANNUAL HEALTH RISK ASSESSMENT**

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| Medical Group Name: | Date: |
| Name of Beneficiary: | MPI: |
| Provider Name: | Provider NPI: |
| Provider Address: | Provider Phone Number: |
| Provider Fax: | Provider E-mail: |

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| **Section 1. GENERAL DEMOGRAPHIC DATA** |

**Sex** *(at birth):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Highest academic level achieved:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Civil Status:**

a. married

b. single

c. divorced

d. separated

e. widowed

f. civil union

**Do you have children?** **a.** **Yes**  How many? \_\_\_\_ **b**. **No**

**Who do you live with?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approximate household annual income (consider everyone living in your home):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_annual/monthly

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| **Section 2. GENERAL HEALTH** |

**In general, how would you described your health status?**

a. Excellent

b. Good

c. Regular

d. Poor

**When was the last time that you visited your Primary Care Provider (PCP)?**

1. Last month
2. During the last three (3) months
3. During the last six (6) months
4. During the last nine (9) months
5. A year ago
6. More than a year ago
7. Never

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| **Recommended Guidlines** | | |
| **BMI (kg/m2)** | **From** | **To** |
| **Underweight** |  | less than 18.5 |
| **Normal** | 18.5 | 25.0 |
| **Overweight** | 25.0 | 29.9 |
| **Obesity** | 30.0 | 39.9 |
| **Extreme Obesity** | greater than 40.0 |  |

**What is your current weight and height** \_\_\_\_\_\_\_\_Lbs. \_\_\_\_\_\_\_\_\_ inches

**Interviewer:** Calculate/Annotate Pt’s Body Mass Index (BMI):\_\_\_\_\_\_\_

**Have you been diagnosed with any of the following conditions?** *Select all that apply.*

* ADHD (Attention Deficit / Hiperactivity Disorder)
* Adult PKU (Phenilketonuria)
* ALS (Amyotropic Lateral Sclerosis)
* Amyotrophic Lateral Sclerosis
* Aplastic Anemia
* Asthma
* Autism
* Cancer
* Children with Special Needs
* Chronic Heart Failure
* COPD (Chronic Obstructive Pulmonary Disease)
* Cystic Fibrosis
* Depression
* Diabetes Mellitus
* Hemophilia
* HIV
* Hypertension
* Invasive Skin Cancer
* Leprosy
* Organ Transplant
* Pregnancy (pregnant at the moment)
* Pulmonary Hypertension
* Renal (including CKD & ESRD)
* Rheumatoid Arthritis
* Scleroderma
* Severe Mental Illness
* SLE / Lupus (Systemic Lupus Erythematosus)
* Squamous cell carcinoma in situ
* Substance use disorder (SUD)
* Tuberculosis
* Other conditions (specify):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any allergies?** a. **Yes** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ b. **No**

**Write ALL the prescription drugs that you take daily:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any difficulty in taking medicine as prescribed by your doctor?** *Select all that apply.*

* 1. I don’t have any difficulty in taking medicine as prescribed by my doctor.
  2. I sometimes find difficulty in reading the instructions.
  3. I don’t understand the instructions well on how to take my medicine.
  4. I regularly forget to take my medicine.
  5. Im confused about what medicine to take and when I have to take them.
  6. I don’t think it is neccesary to take my medicine all the time.
  7. I don’t like the side effects of the medicine.
  8. Other difficulty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In the past 4 weeks, did any medical condition prevented you from being able to work or do any other activity?**

☐ Yes ☐ No

**In the past 7 days, how much pain have you felt?** ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(on a scale from 1 to 10, 1 being the lowest and 10 being most intense)*

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| ***Select all you had done in the past 12 months:*** | **Yes** | **No** | **Does not remember** | **Does not apply** |
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| **Cervical Cancer Evaluation** |  |  |  |  |
| **Colon Cancer Detection** *(Specify)*   1. Guaiac-based fecal occult blood test (gFOBT) 2. Fecal immunochemical test (FIT) 3. Sigmoidoscopy 4. Colonoscopy |  |  |  |  |
| **Vacunas** |  |  |  |  |
| **Influenza** |  |  |  |  |
| **Pneumococcal** |  |  |  |  |
| **COVID-19** |  |  |  |  |
| **Other:** |  |  |  |  |
| **Dentist visit:** |  |  |  |  |
| **Other medical visit or study:** |  |  |  |  |
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**Has your primary care provider ordered you to use any of the following equipment or therapies?** Select all that apply.

1. Mechanical Ventilator
2. CPAP
3. BPAP
4. Ulcer/Wound care
5. Enteral Feeding
6. Durable Medical Equipment a/or Supply *(wheelchair, bed, gel mattress, catherer & other)*
7. Prothesis and/or Orthotics
8. Physical Therapy
9. Occupational Therapy
10. Ostomy supplies
11. Oxygen
12. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
13. None

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| **Section 3. REGULAR DAY ACTIVITY** *(Katz ADL Index)* |

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| **ACTIVITIES**  Points (“1” or “0”) | **Independent**  (1 Point)  **NO** supervision, direction, or personal assistance | **Dependent**  (0 Points)  **WITH** supervision, direction, personal assistance, or total care |
| **BATHING**  Points: \_\_\_\_\_\_\_\_\_\_ | (1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity. | (0 POINTS) Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing. |
| **DRESSING**  Points: \_\_\_\_\_\_\_\_\_\_ | (1 POINT) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes. | (0 POINTS) Needs help with dressing self or needs to be completely dressed. |
| **TOILETING**  Points: \_\_\_\_\_\_\_\_\_\_ | (1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help. | (1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help. |
| **TRANSFERRING**  Points: \_\_\_\_\_\_\_\_\_\_ | (1 POINT) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable | (0 POINTS) Needs help in moving from bed to chair or requires a complete transfer. |
| **CONTINENCE**  Points: \_\_\_\_\_\_\_\_\_\_ | (1 POINT) Exercises complete self-control over urination and defecation. | (0 POINTS) Is partially or totally incontinent of bowel or bladder |
| **FEEDING**  Points: \_\_\_\_\_\_\_\_\_\_ | (1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person | (0 POINTS) Needs partial or total help with feeding or requires parenteral feeding. |
| **TOTAL POINTS: \_\_\_\_\_\_\_\_ 6 = High** *(patient independent)* **0 = Low** *(patient very dependant)* | | |

Traducido de: <https://hign.org/consultgeri/try-this-series/katz-index-independence-activities-daily-living-adl>

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| **Section 4. UTILIZATION** |

**How many times have you visited the Emergency Room in the past six (6) months?**

1. 0 visits
2. 1 – 3 visits
3. 4 – 7 visits
4. More than 7 visits

**How many times have you been hospitalized in the past 12 months?**

* 1. 0
  2. 1
  3. 2
  4. 3 or more

**During the last month, Were you admitted to a hospital?** a. Yes b.No

**If you were hospitalized during last month**, Did your PCP do a medication reconciliation after being discharged? a. Yes b.No

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| **Sección 5. HEALTH HABITS** |

**Indicate which of the following you use:**

**Cigarrettes:** ☐ Yes ☐ No

**Cigar:** ☐ Yes ☐ No

**E-Cigarette** (Vaping, juuling):

☐ **Yes** a. tobacco/nicotine b. cannabis c. other \_\_\_\_\_\_\_\_\_\_\_ ☐ **No**

**Other:** (pipe, hooka) ☐ **Yes** \_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_ ☐ **No**

**Do you practice “safe-sex”?** (Ex. Condom)**:** ☐ N/A ☐ Yes ☐ No

**How many alcoholic beverages (wine, mixed-drinks, beer) do you usually consume per day?** \_\_\_\_\_\_\_

**During the last 7 days, how many portions of fruits or vegetables have you eaten per day?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you engage in physical activity?**

a. **Yes**  Type of activity and how many times per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. **No**

**How do you transport usually?** Choose one (1) alternative*.*

1. I drive myself.
2. Somebody drives me (relative, friend)
3. I use public transportation
4. I use taxi (Ex. Uber)

**If older than 65 years**: During the last three months, Have you fallen down?

* 1. Yes
  2. No
  3. Does not apply

**Have you prepared Advance (anticipated) Medical Directives in case you are in a medical situation where you cannot communicate your will about what type of treatments you want (or do not want) to receive?**

Yes b. No

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| **SOCIAL NEEDS** |

***Choose all that apply to you***:

\_\_ I am without transportation.

\_\_ I do not have a caregiver but I need one.

\_\_ I am a caregiver for and older adult or person with disability.

\_\_ I don't have a safe place to live.

\_\_ I do not have enough resources to attain food.

\_\_ I do not own a refrigerator or it doesn't work.

\_\_ I don't have a way/or place to cook my food.

\_\_ Some days of the week I have no one to assist me with my daily living activities. (bathe, feeding, move from bed to chair, other)

**Are you employed?**

☐ **Yes** ☐ Full-time ☐ Part-time

☐ **No**

**Do have a permanent housing?**

a. **Yes.**  Is your housing situation safe/secure? \_\_Yes \_\_\_No

b. **No**. Who do you live with/ or where? (Shelter, outdoor, car, relatives, or friends) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 6. BEHAVIORAL HEALTH**

**Indicate how frecuently you have felt like this during the last two (2) weeks*:*** *(Choose only one answer per each question)*

1. **How often have you felt little interest or pleasure in doing things?**

a. Never

b. Some days

c. More than half of the time

d. Almost every day

1. **How often have you felt have felt down, depressed, or hopeless?**

a. Never

b. Some days

c. More than half of the time

d. Almost every day

1. **How often have you had trouble sleeping/staying asleep, or sleeping too much?**
   1. Never

b. Some days

c. More than half of the time

d. Almost every day

1. **How often have you felt tired or low on energy?**
   1. Never

b. Some days

c. More than half of the time

d. Almost every day

1. **How often do you have poor appetite or overeat??**

a. Never

b. Some days

c. More than half of the time

d. Almost every day

1. **How often have you felt that you lack self-esteem, that you are a failure, or that you have let yourself or your family down?**

a. Never

b. Some days

c. More than half of the time

d. Almost every day

1. **How often have you had difficulty concentrating on things such as reading the newspaper or watching television?**

a. Never

b. Some days

c. More than half of the time

d. Almost every day

1. **How often do you move or speak so slowly that other people can tell or, on the contrary, are so agitated or restless that you move much more than usual?**

a. Never

b. Some days

c. More than half of the time

d. Almost every day

1. **How often have you had thoughts of being better off dead or harming yourself or others in some way?**

a. Never

b. Some days

c. More than half of the time

d. Almost every day

1. *(ONLY If you answered “b” “c”, “d” in items 1-9)*

**How difficult has it been for you to do your job, take care of your home, or get along with other people because of these problems?**

a. Absolutely not difficult

b. Somewhat difficult

c. Very difficult

d. Extremely difficult

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| **Section 7**. **Do you have any health needs you would like to communicate or any commentary?*****(Interviewer:*** *Write enrollee’s need or comment)* |
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| **Section 8. OBSERVATIONS** *(Take notes of other needs identified by interviewer, e.g., referral to management program, other referrals, perceived risk factors.)* |
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