Patient Name_____Date_____Provider_____

Health Risk Assessment Form

Please complete all sections before seeing your provider

In general, my overall health is: ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

List any hospitalizations, major illness, or visits to the emergency room since last year or last visit

Date	Reason	Location

Medical History

Personal and Family Medical History ☐ No changes since last year/visit						
	Me	Father	Mother	Siblings	Children	Specify Disease
Coronary Disease						
High Blood Pressure						
High Cholesterol						
Cerebral Vascular Disease / Stroke						
Renal Disease						
Cancer						
Diabetes						
Aortic Aneurysm						
Amputation		Location:				

Past Surgeries	Date	Past Surgeries	Date

Names of All Providers / Specialists You See:

Doctor's Name	Specialty Type and Reason You See Them

List of Medical Equipment/Service Providers

Supply	Who provides this service for you?
Oxygen/CPAP	
Diabetic Supplies	
Home Health	
Other	

Patient Name_____Date_____Provider_____

Changes in medications or allergies since last year or last visit ☐ No changes since last year/visit

New patients may document additional medications on the back of this form

Medication	Dose	Reason for Taking

Allergies	Reaction	Allergies	Reaction

Medications: What pharmacy fills your prescriptions? _____

Are you having trouble taking your medications as prescribed? Yes ☐ No ☐

Are you interested in having your prescriptions sent to your home? Yes ☐ No ☐

Accident Prevention:

Do you wear seatbelts in the car? ☐ Yes ☐ No

Do you have smoke detectors at home? ☐ Yes ☐ No

Do you have carbon monoxide detectors? ☐ Yes ☐ No

Do you have firearm(s) at home? ☐ Yes ☐ No If yes, locked up? ☐ Yes ☐ No

Activities of Daily Living

Do you require assistance with any of the following activities?

Using the telephone	☐ Yes ☐ No	Eating	☐ Yes ☐ No
Shopping	☐ Yes ☐ No	Getting from bed to chair	☐ Yes ☐ No
Meal preparation	☐ Yes ☐ No	Dressing	☐ Yes ☐ No
Housekeeping	☐ Yes ☐ No	Bathing	☐ Yes ☐ No
Laundry	☐ Yes ☐ No	Walking	☐ Yes ☐ No
Driving/taking taxi or bus	☐ Yes ☐ No	Getting on/off toilet	☐ Yes ☐ No
Taking medications	☐ Yes ☐ No	Urinary/Bowel Incontinence	☐ Yes ☐ No
Handling finances	☐ Yes ☐ No		

Would you like to speak to your provider about bladder control or trouble with urinary leakage? ☐ Yes ☐ No

I have someone available to help if needed (for a sick day) ☐ Yes, any time ☐ Yes, sometimes ☐ Not really

Personal concern about your memory - or family mentions concern ☐ Yes ☐ No

Diet: ☐balanced ☐vegetarian ☐diabetic ☐low salt ☐low fat ☐low carb ☐other: _____

Do you exercise every day? ☐ No ☐ Yes If not daily, how often? _____

Have you had any falls in the past year? ☐ No ☐ Yes If yes, any injuries: _____

I use a: ☐ cane ☐ prosthetic ☐ walker ☐ wheelchair/scooter ☐ other: _____

Patient Name_____Date_____Provider_____

In the last two weeks check (√) how often you have been bothered by the following:	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have Noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
Add columns for total score:				

If you checked *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Do you drink alcohol? ☐ Yes ☐ No ☐ I No longer drink alcohol

How many times in the last year have you had more than 5 drinks (male)/4 drinks (female) in one day? ____

☐ **I'm interested in talking more about my alcohol use**

Have you ever smoked or chewed tobacco or smoked marijuana? ☐ No ☐ Yes ☐ Current: _____ per day

☐ **I'm interested in help to stop using** _____

Do you use illicit drugs? ☐ No ☐ Yes ☐ **I'm interested in help to stop using** _____

Do you ever take prescription drugs for non-medical reasons? ☐ No ☐ Yes

If yes, how often? ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

☐ **I'm interested in talking more about prescription drug use**

Patient Name_____Date_____Provider_____

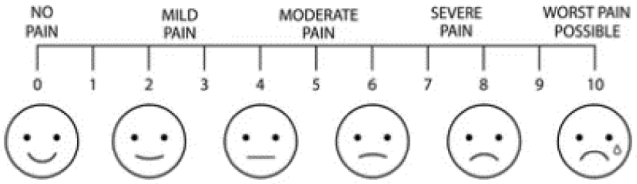
Pain Assessment

Is the pain constant? ☐ Yes ☐ No

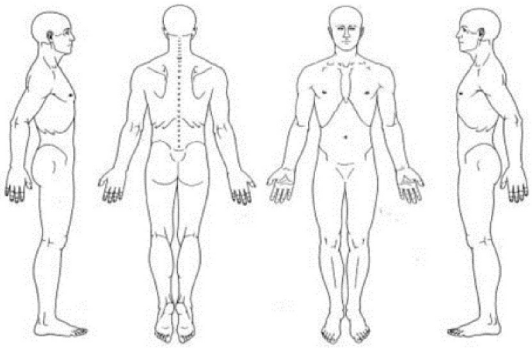
Type of pain: ☐ Ache ☐ Deep ☐ Sharp ☐ Hot ☐ Cold ☐ Sensitive skin ☐ Other: _____

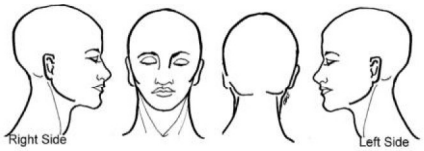
Onset, duration, and variation: _____

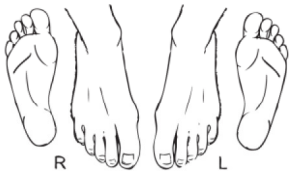
Intensity: on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine, how is your pain right now?



Mark location of pain on diagrams below:







What relieves the pain? _____

I'm interested in other options to manage my pain: ☐ Yes ☐ No

Do you see a specialist to manage your pain? ☐ Yes ☐ No Specialist: _____

Do you have a prescription for pain medication? ☐ Yes ☐ No

If yes, ☐Post-surgery (short term) or ☐ Chronic pain

If you have a prescription for pain management, please complete:

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal Drugs	2	3
Rx Drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal Drugs	4	4
Rx Drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Patient Name_____Date_____Provider_____

Health Screenings:

Do you have trouble with speech? ☐ Yes ☐ No

Do you have trouble hearing? ☐ Yes ☐ No Do you wear a hearing aid? ☐ Yes ☐ No

Last hearing exam: _____

Do you have trouble seeing? ☐ Yes ☐ No Do you wear glasses or contacts? ☐ Yes ☐ No

Most recent diabetic retina (dilated) eye exam: ☐ I'm not a diabetic

- Mo/Yr _____/_____
- By Dr. _____ Ophthalmologist / Optometrist (please circle one)
- Location (name of eye doctor's office, if known) _____
- Result of retina exam _____ (e.g., negative for retinopathy)

When was your most recent:

Mammogram: Mo/Yr: _____Where: _____Result: _____

Colonoscopy: Mo/Yr: _____Where: _____ Result: _____

I elected another colon test: ☐ FIT-DNA year_____ Result: _____

☐ FOBT year_____ Result: _____

☐ Other colon screening: _____ Yr._____Result: _____

Osteoporosis Screening (DEXA) bone scan:

- Mo/Yr _____/_____ Location: _____ (Name of imaging center)
- ☐ I received my bone scan in my home

I have a: ☐ Living will ☐ Medical Order for Life Sustaining Treatment (MOST)

☐ Medical Power of Attorney ☐ Other: _____

☐ **I'm interested in learning more about documenting my wishes for end-of-life decision-making**

I'd like to talk with a Care Coordinator about _____.
A Care Coordinator can assist with managing chronic diseases like diabetes, heart failure and COPD. They can help find options for: reducing cost of medications, transportation, long-term care planning, caregiver support, end of life decision-making, resources for mental health or substance abuse.

_____Provider Signature (reviewed)

☐ No cognitive issues detected ☐ Cognition screen prompts Mini-Cog or SLUM, results and plan in visit note.

For Office Use Only

Referral to Care Coordinator completed _____(initials)

Personalized Preventive Plan of Services (PPPS) completed and given to patient: _____ (initials)

SCAN INTO PATIENT'S CHART PHP Example 11/2021

Example to customize for each practice

Annual Physical Examinations

At Smoky Hill Family Medicine we believe in a proactive approach to keeping you healthy, and preventative medicine is a key component to achieving this goal. As a patient, it is important to understand what services qualify as preventative during your Annual Exam. Depending on your health plan, your insurance may fully cover certain preventative benefits.

Preventative services include:

- Age/ Gender focused exam
- Advice for disease prevention and healthy living
- Discussions in regards to previously identified risk factors (i.e. smoking)
- Certain Lab/X-ray tests to screen for diseases that you may be at risk for due to age, gender or lifestyle
- Standard age based immunizations
- Management of previously diagnosed chronic problems that are relatively STABLE

PLEASE NOTE: If you receive care beyond what your preventative benefits cover, you may incur additional copays and/or deductibles for those services.

Services NOT covered by your preventative visit* are subject to additional charges which include, but are not limited to:

- New problems that require lab test, x-ray, or other evaluation
- New problems that require prescription medication
- Chronic problems that are significantly uncontrolled and require evaluation, management or change in medications
- Immunizations not deemed preventative under your insurance plan.
- If you have been previously diagnosed with cholesterol, thyroid concerns, etc your insurance WILL NOT consider your blood work as preventative screening. It will fall under your diagnostic coverage.

*Please note that this handout does not describe or completely define your preventative benefits. In the event of a discrepancy between this document and your Evidence of Coverage (EOC)/Membership Agreement will take precedence over this document.

If you have specific questions about your preventative benefits, please contact your insurance company directly.

Thank You from the Staff at Smoky Hill Family Medicine!

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Joel Shebowich, MD Liberty Amador, MD Jennifer Pearson, PA Kimberly Zier, NP