

Today's Date: _____

Patient Name: _____



Annual Wellness Visit Health Risk Assessment

Personal Information

1. Preferred Pharmacy: _____
2. Preferred Lab: _____
3. Preferred imaging and x-ray facility: _____

Care Team

Specialty	Physician Name	Last Seen
Cardiology		
Dentist		
Dermatologist		
Ear, Nose & Throat (ENT)		
Endocrinologist		
Eye/Optometry/Ophthalmologist		
Gastroenterologist		
Gynecologist		
Hematologist/Oncologist		
Nephrologist		
Neurologist		
Orthopedist		
Podiatrist		
Pulmonologist		
Psychiatrist/Psychologist		
Rheumatologist		
Urologist		
Other:		

Have you seen a dentist within the last 6 months:	Yes	No
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Pain Assessment

In the past 2 weeks, how often have you felt pain?

Never	Almost never	Sometimes	Most times	Almost all of the time
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Where is the pain? _____

Rate your pain on the following scale:

1 😊 | 2 😊 | 3 😊 | 4 😊 | 5 😊 | 6 😊 | 7 😊 | 8 😊 | 9 😊 | 10 😊

Allergies – Drugs, Food Environment

Medications – Prescriptions, Vitamins, Over-the-Counter

Name	Dose	Name	Dose

Self & Family History *(mark the columns that apply)*

	None	Self	Parent	Brother	Sister	Child
Congestive Heart Failure						
Diabetes						
COPD (Chronic Lung Disease) or Asthma						
Hypertension						
Stroke						
Kidney Disease						
Obesity						
Liver Disease						
Bipolar Disorder or Schizophrenia						
Dementia						
Cancer						
Depression						
Significant Surgeries:						

Functional Status Assessment

Are you able to care for yourself independently?	Yes	No	Note:
Are you blind or do you have difficulty seeing?	Yes	No	Note:
Are you use eyeglasses or contacts?	Yes	No	Note:
Are you deaf or have serious difficulty hearing?	Yes	No	Note:
Do you use hearing aids or other devices?	Yes	No	Note:
Do you have difficulty concentrating, remembering or making decisions?	Yes	No	Note:
Do you have difficulty walking or climbing stairs?	Yes	No	Note:
Do you have difficulty dressing, bathing, grooming or toileting?	Yes	No	Note:
Do you have difficulty doing errands alone?	Yes	No	Note:
Do you have transportation difficulties?	Yes	No	Note:

Physical Activity

How many days a week do you exercise?	0	1-2	3-4	5+	I don't know	
How intense is your exercise?	Light	Moderate	Heavy	Very Heavy	I don't know	I don't exercise

Tobacco, Alcohol and Drug Use

Do you use any tobacco products? (Cigarettes, chew, snuff, pipes, cigar)	Yes	No
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If so, are you interested in quitting tobacco?	Yes	No	I don't use tobacco
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How many times in the past year have you had 4 or more drinks in a day?	Never	Moderate	Heavy	Number of days:
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Do you use any illegal drugs or take any prescription medications that have not been prescribed to you?	No	Yes (please describe):
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Advance Directives

Does your family or friends know what you want in an emergency situation or if you could not speak for yourself:

No | **Yes** and I have completed (mark all that apply):

☐	A living will (Advance Directive)
☐	DNR
☐	Power of Attorney for Health Care
☐	POLST (in some states known as: POST, MOST, MOSLST, TPOPP)
☐	Five wishes

Would you like more information?

☐ Yes	☐ No	☐ Unsure
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Home/Safety

What is your housing situation like? (mark all that apply):

☐	Live with one or more children or dependent
☐	Live in an assisted living facility
☐	Live alone
☐	I have housing today, but I am worried about losing housing in the future
☐	I do not have housing (I am staying with others, on a beach, in a car, abandoned building, bus or train station or in a park

Social/Emotional Support

Which of the following applies to you? (mark all that apply):

☐	I have a supportive family
☐	I have supportive friends
☐	I participate in church, clubs, or other groups
☐	None

Would you like more information?

☐ Yes	☐ No	☐ Unsure
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Sleep

How many hours of sleep do you usually get?	0-3	4-6	7-10	I don't know
Do you snore, or has anyone told you that you snore?	Yes	No	I don't know	
In the past 7 days, how often have you felt sleepy during the day?	Often	Sometimes	Almost Never	Never
Have you ever been diagnosed with Sleep Apnea or other sleep disorders?	Yes	No	I don't know	
Are you currently using or have you used C-PAP/Bi-PAP?	Yes	No		

Depression Screening (PHQ-2)

In the past 2 weeks, how often have you been bothered by the following problems:	Not at all	Several Days:	More than half of those days:	Nearly every day:
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Total Score: _____

Steady Fall Risk *(mark all that apply):*

Yes	No	I have fallen in the past year
Yes	No	I use or have been advised to use a can or walker to get around safely
Yes	No	Sometimes I feel unsteady when I am walking
Yes	No	I steady myself by holding onto furniture when walking at home
Yes	No	I am worried about falling
Yes	No	I need to push with my hands to stand up from a chair
Yes	No	I have some trouble stepping up onto a curb
Yes	No	I often have to rush to the toilet
Yes	No	I have lost some feeling in my feet
Yes	No	I take medicine that sometimes makes me feel light-headed or more tired than usual
Yes	No	I take medicine to help me sleep or improve my mood
Yes	No	I often feel sad or depressed

Total Score: _____

Do you have a problem with the following at your home? *(mark all that apply):*

	Bug infestation			
	Mold			
	Lead pain or pipes			
	Inadequate heat			
	Oven or stove not working			
	No or not working smoke detectors			
	Water leaks			
	None of the above			
Do you feel safe in your home?	Yes	No		
Does your home have working smoke alarms?	Yes	No	I don't know	
Do you have area rugs on your floor(s)?	Yes	No		
Do you have handrails in the bathroom?	Yes	No		
Do you have proper lighting in your home?	Yes	No		
Do you have handrails for the stairs?	Yes	No	I don't have stairs	
Do you fasten your seatbelt in vehicles?	Yes	No	I don't ride in vehicles	

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee



Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	
2. Did you lose a parent through divorce, abandonment, death, or other reason?	
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	
6. Did you live with anyone who went to jail or prison?	
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	
9. Did you feel that no one in your family loved you or thought you were special?	
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health?

Not Much

Some

A Lot

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

5/5/20

This questionnaire is intended for female patients ages 21–41.
Please complete if applicable

Extended–Hurt, Insulted, Threaten, Scream (E-HITS)

Over the last 12 months, how often did your partner:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Frequently (5)
1. Physically hurt you?	☐	☐	☐	☐	☐
2. Insult your or talk down to you?	☐	☐	☐	☐	☐
3. Threaten you with harm?	☐	☐	☐	☐	☐
4. Scream or curse at you?	☐	☐	☐	☐	☐
5. Force you to have sexual activities?	☐	☐	☐	☐	☐

Score range: 5–25

Cutoff for IPV: ≥ 7

Iverson KM, King MW, Gerber MR, et al. Accuracy of an intimate partner violence screening tool for female VHA patients: a replication and extension. *J Trauma Stress*. 2015 Feb;28(1):79–82. doi: 10.1002/jts.21985 [doi]. PMID: 25624170. [[PubMed](#)] [[CrossRef](#)]

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered
by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off 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 ☐
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NIDA Clinical Trials Network

The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 1

Web Version: 2.0; 4.00; 09-19-17

General Instructions:

The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year. Question 2 should be answered only by males and Question 3 only by females. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

Segment:

Visit number:

1. In the PAST 12 MONTHS, how often have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?

☐ Daily or Almost Daily

☐ Weekly

☐ Monthly

☐ Less Than Monthly

☐ Never

2. In the PAST 12 MONTHS, how often have you had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by males).

☐ Daily or Almost Daily

☐ Weekly

☐ Monthly

☐ Less Than Monthly

☐ Never

3. In the PAST 12 MONTHS, how often have you had 4 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by females).

☐ Daily or Almost Daily

☐ Weekly

☐ Monthly

☐ Less Than Monthly

☐ Never

4. In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

☐ Daily or Almost Daily

☐ Weekly

☐ Monthly

☐ Less Than Monthly

☐ Never

5. In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you? Prescription medications that may be used this way include: Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)

☐ Daily or Almost Daily

☐ Weekly

☐ Monthly

☐ Less Than Monthly

☐ Never



Protocol for Responding to and Assessing
Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

☐	Yes	☐	No	☐	I choose not to answer this question
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2. Which race(s) are you? Check all that apply

☐	Asian	☐	Native Hawaiian
☐	Pacific Islander	☐	Black/African American
☐	White	☐	American Indian/Alaskan Native
☐	Other (please write):		
☐	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

☐	Yes	☐	No	☐	I choose not to answer this question
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4. Have you been discharged from the armed forces of the United States?

☐	Yes	☐	No	☐	I choose not to answer this question
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5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? _____

☐	I choose not to answer this question
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7. What is your housing situation today?

☐	I have housing
☐	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
☐	I choose not to answer this question

8. Are you worried about losing your housing?

☐	Yes	☐	No	☐	I choose not to answer this question
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9. What address do you live at?

Street: _____

City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

☐	Less than high school degree	☐	High school diploma or GED
☐	More than high school	☐	I choose not to answer this question

11. What is your current work situation?

☐	Unemployed	☐	Part-time or temporary work	☐	Full-time work
☐	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
☐	I choose not to answer this question				

12. What is your main insurance?

☐	None/uninsured	☐	Medicaid
☐	CHIP Medicaid	☐	Medicare
☐	Other public insurance (not CHIP)	☐	Other Public Insurance (CHIP)
☐	Private Insurance	☐	

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

☐	I choose not to answer this question
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14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
I choose not to answer this question					

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

Yes, it has kept me from medical appointments or
Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
No
I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

Less than once a	1 or 2 times a week
3 to 5 times a week	5 or more times a
I choose not to answer this question	

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

Not at all	A little bit
Somewhat	Quite a bit
Very much	I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

Yes	No	I choose not to answer this
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19. Are you a refugee?

Yes	No	I choose not to answer this
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20. Do you feel physically and emotionally safe where you currently live?

Yes	No	Unsure
I choose not to answer this question		

21. In the past year, have you been afraid of your partner or ex-partner?

Yes	No	Unsure
I have not had a partner in the past year		
I choose not to answer this question		