Detailed Health Assessment

Name: _____ Date of birth: _____

Our clinic has achieved certification as a Patient Centered Medical Home. Patient-centered is a way of saying that you, the patient, are the most important person in the health care system. You are at the center of your health care. To provide the best quality care, it is important we keep information in your health record detailed and up-to-date.

Please fill out this questionnaire and provide your answers to a member of the Horizon Healthcare team for scanning to your medical record. Thank you for your time in completing this form. We appreciate you sharing your medical information with your medical home to enable us to provide the most comprehensive care to you, the center of our focus.

1. What is your age? _____

2. What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

3. What is your race?(Check all that apply) ☐White ☐Black or African American ☐Asian☐Hawaiian or other Pacific Islander ☐American Indian or Alaskan Native ☐Hispanic or Latino Origin ☐ Other_____

4. Do you wear glasses or contact lenses? ☐Yes ☐ No If yes, what kind? _____

5. Are you legally blind? ☐ Yes

6. Do you have trouble hearing? ☐Yes ☐ No

7. Do you wear a hearing aid? Which ear? R☐ L☐ Both☐

8. Do you have a living will or Power of Attorney for Healthcare? ☐Yes ☐ No If so, do we have a copy of it and what type of advanced directive do you have?_____

9. When was your last mammogram? ☐ N/A Date: _____ If due, I decline. ☐

What was the result of your mammogram? ☐ Normal ☐ Abnormal

10. When was your last PAP Smear? ☐ N/A Date: _____ If due, I decline. ☐

What was the result of your Pap Smear? ☐ Normal ☐ Abnormal

11. When was your last colonoscopy? ☐ N/A Date: _____ If due, I decline ☐

What was the result of your Colonscopy? ☐ normal ☐ abnormal

12. When was your last influenza shot? Date: _____ If due, I decline. ☐

13. When was your last pneumonia shot? Date: _____If due, I decline. ☐

14.. If diabetic, when was your last diabetic eye exam? ☐ N/A Date: _____ If due, I decline. ☐

What was the result of your diabetic eye exam? ☐ Normal ☐ Abnormal

15. During the **past four weeks**, how would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

16. During the **past four weeks**, how much body pain have you had?

☐ No pain ☐ Mild Pain ☐ Moderate pain ☐ Severe pain

17. How often in the **past four weeks** have you been *bothered* by any of the following problems:

	Never	**Seldom**	**Sometimes**	**Often**	**Always**
Falling or Dizzy Upon Standing					
	Never	**Seldom**	**Sometimes**	**Often**	**Always**
Sexual Problems					
Trouble Eating Well					
Teeth or Denture Problems					
Problems Using the Telephone					
Tiredness or Fatigue					

18. Due to any health problems you may have, do you need the help of another person to perform your personal care needs such as eating, bathing, dressing, or getting around the house? ☐Yes ☐No

19. How confident are you that you can control and manage most of your health problems?

☐Very confident ☐Somewhat confident ☐Not very confident ☐I do not have any health problems

20. How often do you have trouble taking medications the way you have been told to take them?

☐ I always take them as prescribed ☐ I sometimes take them as prescribed

☐ I seldom take them as prescribed ☐ I do not take any medications

21. During the **past four weeks**, was someone available to help you if you needed and wanted help?

☐ Yes, as much as I wanted ☐ Yes, quite a bit ☐ Yes, some ☐ No, not at all

22. Can you go shopping for groceries or clothing without someone's help? ☐ Yes ☐ No

23. Can you prepare your own meals? ☐ Yes ☐ No

24. Can you manage your money without someone's help? ☐ Yes ☐ No

25. Do you have difficulties driving a car?

☐ Yes, often ☐ Sometimes ☐ No ☐ Not applicable, I do not drive

26. Do you smoke? ☐ No ☐ Yes, but I'd like to quit ☐ Yes, but I'm not ready to quit

27. Are there smokers in the home? ☐ Yes ☐ No

28. During the **past four weeks**, how many alcoholic beverages have you had? (Example: Wine, beer, or any hard liquor)

☐10 or more per week ☐ 6-9 per week ☐ 2-5 per week ☐ One drink per week ☐ No alcohol at all

29. Do you drink or consume caffeine on a daily basis? ☐ Yes ☐ No

30. What is your occupation/job? _____ Where do you work? _____

31. What level of education did you complete? ☐ GED ☐ High School ☐ Associates ☐ Bachelors ☐ Masters ☐ Other: _____

32. What type of house do you live in? ☐ Single family ☐ Multi-family ☐ House ☐ Trailer ☐ Apartment

33. Do you exercise? ☐ Yes ☐ No

If yes, do you exercise for 20 minutes three or more days a week? ☐ Yes, most of the time ☐ Yes, some of the time ☐ No

34. Do you have any religious preferences that affects your health care decisions? ? ☐ Yes ☐ No

If yes, what are they: _____

35. Do you have a carbon monoxide monitor/alarm? ☐ Yes ☐ No

36. Do you have a fire/smoke alarm? ☐ Yes ☐ No

37. Is there Radon in the home? ☐ Yes ☐ No ☐ Not tested

38. Have you fallen **two or more** times in the past year? ☐ Yes ☐ No If YES, how many? _____

39. Are you afraid of falling? ☐ Yes ☐ No

40. Do you own firearms? ☐ Yes ☐ No If YES, are they locked up for safety? ☐ Yes ☐ No

41. Do you have central heat/air conditioning? ☐ Yes ☐ No

42. If no central heat, what type of heat do you use? ☐ Coal ☐ Wood ☐ Gas ☐ Oil ☐ Solar

43. What type of bed do you sleep on ☐ Box spring ☐ Waterbed ☐ Foam ☐ Allergy covered

44. What type of floors do you have? ☐ Carpet ☐ Hardwood ☐ Tile/Linoleum

45. Do you have pets in your home? ☐ Yes ☐ No If yes, what kind and how many? _____

46. During the **past four weeks,** how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, downhearted, or blue?

☐ Not at all ☐ Slightly ☐Moderately ☐ Quite a bit ☐ Extremely

47. During the **past four weeks,** has your physical and emotional health limited your social activities with family, friends, neighbors, or groups? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

48. Do you have a history of recreational drug use? If so, what kind? _____

49. Do you have suicidal thoughts? ☐Yes ☐No

50. Do you have homicidal thoughts? ☐ Yes ☐ No

51. Have you ever been or are you currently diagnosed with a mental disorder? If so, type?_____

52. What gender where you born? ☐Male ☐Female

53. What gender do you identify with? ☐ Male ☐Female

54. What is your sexual interest? ☐Male ☐Female ☐Bi-sexual

55. Do you use contraceptives? ☐Yes ☐ No If yes, what kind? _____

56. Do you have a history of sexually transmitted infections? ☐Yes ☐ No

If YES, what type: _____

57. What is your HIV status? ☐ Negative ☐ Positive ☐ Not tested

Please give this form to your nurse. Your care is important to us.
Thank you for choosing Horizon Healthcare.

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