UT MEDICINE
HEALTH SCIENCE CENTER SAN ANTONIO

Health Risk Assessment Questionnaire

Office Use Only: ☐ Medicare Wellness Visit ☐ Welcome to Medicare Visit

Name: _____

Date of Birth: _____

In general, would you say your health is?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

In general, how satisfied are you with your life?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Very Dissatisfied

In the past 7 days, how much pain have you felt?

- ☐ None
- ☐ Some
- ☐ A lot

Do you usually exercise at least 30 minutes or more, 5 days a week?

- ☐ Yes
- ☐ No

Do you usually eat a diet that has at least 4 servings of fruit & vegetables, includes whole grain & fiber and avoids other than occasional servings of high fat foods?

- ☐ Yes
- ☐ No

How would you describe the condition of your mouth and teeth (including false teeth or dentures)?

- ☐ Excellent
- ☐ Good
- ☐ Poor

In a typical week, how much alcohol do you drink?

- ☐ None
- ☐ One drink per day or less
- ☐ Two drinks per day
- ☐ More than 2 drinks per day

Do you ever have 5 or more alcoholic drinks on one occasion?

- ☐ Yes
- ☐ No

Do you always fasten your seat belt when you are in the car?

- ☐ Yes
- ☐ No

Do you know where to locate and properly use a first aid kit and fire extinguisher in case of an emergency?

- ☐ Yes
- ☐ No

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

- ☐ Yes
- ☐ No

In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

- ☐ Yes
- ☐ No

In the past 7 days have you had any problems staying or falling asleep?

- ☐ Yes
- ☐ No

In the past 7 days have you had problems with constipation?

- ☐ Yes
- ☐ No

In the past year have you had:

- ☐ 2 or more falls or a fall with an injury
- ☐ No falls or 1 fall with no injury

Does your home have rugs in the hallway?

- ☐ Yes
- ☐ No

Does your home have grab bars in the bathroom?

- ☐ Yes
- ☐ No

Does your home have handrails on the stairs?

- ☐ Yes
- ☐ No

Does your home have good lighting?

- ☐ Yes
- ☐ No

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Do you or any of your friends or family members have any concerns about your memory?

- ☐ Yes
- ☐ No

Do you have any problems with your hearing?

- ☐ Yes
- ☐ No