Health Risk Assessment (HRA)

1. In general, how would you rate your health?
   - Poor
   - Fair
   - Average
   - Good
   - Excellent

2. Do you need assistance with any of the following*? (check all that apply)*
   - Walking
   - Dressing
   - Eating
   - Bathing
   - Laundry
   - Using the Phone
   - Food Preparation
   - Finances
   - Taking Medications
   - Housekeeping
   - Shopping
   - Toileting
   - Driving
   - None of the above

3. Are you experiencing any of the following? *(check all that apply)*
   - Loneliness
   - Anger
   - Stress
   - Fatigue
   - Social Isolation
   - None of the above

4. Do you have any of the following in your home? *(check all that apply)*
   - Smoke Alarms
   - Bathroom Grab Bars
   - Night Lights
   - Throw Rugs

5. Are you having any problems with your teeth or gums?
   - Yes
   - No

6. In the past 12 months have you used prescription medication more than prescribed or that were not prescribed to you?
   - Yes
   - No

7. Have you had any difficulty obtaining and taking your medication as prescribed, including cost or other factors?
   - ○ Yes
   - ○ No

   If yes, please specify: _____

8. Have you had any recent history of fractures, falls, or musculoskeletal issues?
   - ○ Yes
   - ○ No

9. Are there any sexual issues that need to be addressed with the provider?
   - ○ Yes
   - ○ No

10. Have you had any inpatient hospital admissions in the last two years?
    - ○ Yes
    - ○ No

11. Do you operate a motor vehicle?
    - ○ Yes
    - ○ No

    If no what is your mode of transportation? _____

12. Do you have any issues with urinary or fecal incontinence?
    - ○ Yes
    - ○ No

13. Do you use any medical equipment at home?
    For example: CPAP, Oxygen, Wheelchair, Cane or Walker
    - ○ Yes
    - ○ No

    If yes, please list the type of medical equipment and what company supplies your medical equipment: _____