Medical Advantage
Accountable Care Organization

Health Risk Assessment

Date:_____ Patient Name: _____ Date of Birth: _____

1. How would you rate your overall health?
   Excellent Very Good Good Fair Poor Very Poor
2. Do you have any concerns about your health? YES NO
   If yes, please list your concerns: _____
3. Please list any surgical history:
   _____
   _____
4. Please list all current and prior medical conditions:
   Current:_____
   _____
   Prior:_____
5. Please list known family history of medical conditions:
   _____
   _____
6. How would you characterize your overall physical functioning?
   Excellent Very Good Good Fair Poor Very Poor
7. Are you physically active? YES NO
   If yes: Type of activity? _____
   How many times per week? _____
   How many minutes at one time? _____
8. Do you characterize yourself as frail? YES NO
   If Yes - Slightly frail Moderately frail Very frail Extremely frail
9. Are you currently using any durable medical equipment? YES NO
   Please circle: Walker, Wheelchair, Cane, Crutches, Hearing Aids, Glucometer, CPAP, Oxygen
   Other:_____
10. What is your pain level? 1 2 3 4 5 6 7 8 9 10
11. Have you had a vision screen in the last year? YES NO
    Date:_____
12. Do you have any concerns regarding your hearing? YES NO
    Please list concerns if yes: _____
13. How would you rate your oral health?
    Excellent Very Good Good Fair Poor Very Poor
14. Have you been to the dentist in the last year? YES NO
    Date:_____
15. How would you rate your diet? **Please choose one:**
    As Advised By Doctor Very Healthy Healthy Moderately Healthy
    Moderately Poor Very Poor

Health Risk Assessment

16. Do you feel overly tired or fatigued? YES NO
17. Do you feel lonely or isolated? YES NO
18. Please list the people currently residing with you and their relationship to you:

_____

19. How is your stress level?
    High Moderately high Moderately low Low Very low
20. Do you have trouble controlling your anger? YES NO
21. Do you currently have a durable power of attorney? YES NO
    a. Is it on file with the practice? YES NO
22. Are you sexually active? YES NO
    a. Sexual partners – Men Women Both
    b. Multiple partners? Yes NO
23. Do you have a history of Sexually Transmitted Infections (STI)? YES NO
24. In the last 30 days, have you used tobacco?
    a. Smoke: __Yes __No
    b. Used a smokeless tobacco product: __Yes __No
25. If yes to above, would you be interested in quitting tobacco use within the next month? __Yes __No
26. In the past 14 days, on how many days did you drink alcohol? ____ # of days
27. On days when you drank alcohol, how often did you drink 4 or more alcoholic beverages on one occasion?
    __ Never
    __ Once during the week
    __ 2-3 times during the week
    __ More than 3 times during the week
28. Do you ever drive after drinking or ride with a driver who has been drinking? __Yes __No
29. Do you currently use or have a history of using IV drugs? YES NO
30. Do you wear a seat belt when you drive or ride in the care? YES NO
31. Please answer the following questions regarding your home safety:
    1. I have steps to enter my home or stairs inside my home YES NO
    2. There are handrails on the stairs YES NO
    3. I have loose throw rugs in my house YES NO
    4. I have clutter on the floors YES NO
    5. I have poor household lighting YES NO
    6. I have grab bars in the bathroom YES NO
    7. Do you use any medical equipment while walking YES NO
    8. Have you fallen in the past year? YES NO

32. Please answer the following questions regarding your abilities:
    1. Can you prepare meals without assistance? YES NO
    2. Can you dress yourself without assistance? YES NO
    3. Can you use the toilet without assistance? YES NO
    4. Can you perform basic hygiene without assistance? YES NO
    5. Can you bathe and/or shower yourself without assistance? YES NO
    6. Do you ever lose your balance or fall when walking? YES NO
    7. Can you use the phone without assistance? YES NO
    8. Can you manage your medication without assistance? YES NO
    9. Can you access your mode of transportation without assistance? YES NO
    10. Can you do your own housework? YES NO
    11. Can you manage your finances without assistance? YES NO
    12. Can you shop without assistance? YES NO
    13. Can you do laundry without assistance? YES NO
33. Have you had any hospital stays in the past 12 months? YES NO
    Date of service(s): _____
    Name of hospital(s) and reason(s) for visit: _____
34. Do you have a family history of an abdominal aortic aneurysm? YES NO
35. Do you have any known medication allergies/reactions: YES NO

    _____ _____

    _____ _____
36. Are you currently using any prescribed opioids (pain medications)? YES NO
    Examples: Fentanyl, Hydrocodone, Morphine, Codeine
37. Have you ever intentionally taken more medication than prescribed or medication that was not prescribed for you? YES NO

MEDICATIONS AND SUPPLEMENTS		
List all medications, vitamins, minerals (like calcium), and supplements (include over-the-counter) *Provide a written list of your medications if available*		
Medication Name	**Dosage and Directions**	**Reason for Medication**

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Please list all doctors and their phone numbers (if known), which you currently see:

(Include eye doctors, dentist, podiatrist, medical equipment supplier, etc.)

Name/Phone:	Name/Phone:

OFFICIAL USE ONLY			
Height:	Weight:	Blood Pressure:	Vision Acuity:
Reviewed By Clinician Name:			
Clinician Signature:		Date:	

Check Your Risk for Falling

Circle "Yes" or "No" for each statement below			Why it matters
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.

Total _____

Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. J Safety Res; 2011: 42(6)493-499). Adapted with permission of the authors.

Four Things You Can Do to Prevent Falls:

① **Speak up.**
Talk openly with your healthcare provider about fall risks and prevention. Ask your doctor or pharmacist to review your medicines.

② **Keep moving.**
Begin an exercise program to improve your leg strength and balance.

③ **Get an annual eye exam.**
Replace eyeglasses as needed.

④ **Make your home safer.**
Remove clutter and tripping hazards.

Learn More

Contact your local community or senior center for information on exercise, fall prevention programs, and options for improving home safety, or visit:

- go.usa.gov/xN9XA
- www.stopfalls.org

1 in 4 people 65 and older falls each year.

Falls can lead to a loss of independence, but they are preventable.

For more information, visit www.cdc.gov/steadi

This brochure was produced in collaboration with the following organizations: VA Greater Los Angeles Healthcare System, Geriatric Research Education & Clinical Center (GRECC), and the Fall Prevention Center of Excellence

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

2017

Stay Independent

Learn more about fall prevention.

STEADI
Stopping Elderly Accidents, Deaths & Injuries

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
☐	☐	☐	☐

Social Determinants of Health Survey

Patient Name: _____ Birthdate: _____/_____/_____

Today's Date: _____/_____/_____

To better meet the health needs of the patients at our practice, we have created a list of questions that we are asking each patient to complete on a yearly basis. Your answers will help us to know if you have needs outside of your general health that could be affecting your wellbeing.

	Question			
	Do you ever eat less food than you feel you should because there is not enough food?	Yes	No	N/A
	In the past 12 months, was there a time when you needed to see a doctor but could not because it cost too much?	Yes	No	N/A
	Do you have a hard time finding work or another steady source of income?	Yes	No	N/A
	Are you worried that in the next few months, you may not have safe housing?	Yes	No	N/A
	In the past year, have you had a hard time paying your utility company bills?	Yes	No	N/A
	Does caring for children, family or friends make it hard for you to take care of your own needs?	Yes	No	N/A
	Do you think completing more education or training would be helpful to you?	Yes	No	N/A
	Do you ever have trouble getting to work, school, the store, and/or appointments because you don't have a way to get there?	Yes	No	N/A
	Do you ever feel unsafe in your home or neighborhood?	Yes	No	N/A
	In the past month, did poor physical or mental health keep you from doing your usual activities?	Yes	No	N/A
?	Would you like assistance with any of these needs?	Yes	No	N/A
!	Are any of your needs urgent? Example: I don't have food or a place to sleep tonight?	Yes	No	N/A

Bladder Control
Assessment Tool

Urology Care FOUNDATION™
The Official Foundation of the American Urological Association

Name:
DOB:

How do I use this Assessment?

Read the questions on both pages and answer them based on the last month. Share your completed assessment with your health care provider. Your answers on this assessment may help you to measure your symptoms and how much they may bother you.

Symptom Questions

Answer each question below on a scale from zero to five. The symptom questions may then be added to get a score from 0 (no symptoms) to 25 (most severe symptoms). The higher your score for these questions, the more severe your symptoms may be.

SYMPTOM QUESTIONS	Not at all	Occasionally	About once a day	About three times a day	About half the time	Almost always	SCORE
Urgency *How often do you have a strong, sudden urge to pass urine where you fear you may leak urine?*	0*	1	2	3	4	5	
Urgency Incontinence *How often have you leaked urine?*	0	1	2	3	4	5	
	None	**Drops**	**1 Tea-spoon**	**1 Table-spoon**	**¼ cup**	**Entire bladder**	
Incontinence *How much urine do you think leaks?*	0	1	2	3	4	5	
	1-6 times	**7-8 times**	**9-10 times**	**11-12 times**	**13-14 times**	**15 or more times**	
Daytime Frequency *How often do you pass urine during the day?*	0	1	2	3	4	5	
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5 times or more**	
Nighttime Frequency *How many times did you wake up to pass urine during the night?*	0	1	2	3	4	5	
TOTAL SYMPTOM SCORE					Add score from right column to find total score.		

National Headquarters: 1000 Corporate Boulevard, Linthicum, MD 21090
Phone: 410-689-3990 • Fax: 410-689-3878 • 1-800-828-7866 • info@UrologyCareFoundation.org • www.UrologyHealth.org
UrologyCareFoundation @UrologyCareFdn @UrologyCareFdn UrologyCareFoun

Bladder Control
Assessment Tool

Quality of Life Questions

For the quality of life questions below, please circle the response that best describes how bothered you have felt over the last month. These questions do not need to be added. This section may help show how your symptoms impact your life.

QUALITY OF LIFE QUESTIONS How much does this bother you:	I am not bothered at all					I am bothered a great deal
Activities *My bladder control has limited activities with friends and family.*	0	1	2	3	4	5
Work *My ability to work or volunteer outside the home has been limited by my bladder control.*	0	1	2	3	4	5
Sleep *Bladder control is keeping me from getting a good night's sleep.*	0	1	2	3	4	5
Exercise *I have had to limit exercise or physical activity due to my bladder control.*	0	1	2	3	4	5
Travel *Bladder control keeps me from traveling, taking trips, or using public transit.*	0	1	2	3	4	5
Feelings *I am embarrassed because of my bladder control.*	0	1	2	3	4	5

The better your health care provider knows the level and impact of your symptoms and quality of life, the better he or she can help you manage them. Even if you are not bothered much about mild symptoms, you and your health care provider may want to discuss what treatment options are available to you.

Disclaimer

This information is not a tool for self-diagnosis or a substitute for professional medical advice. It is not to be used or relied on for that purpose. Please talk to your urologist or health care provider about your health concerns. Always talk to a health care provider before you start or stop any treatments, including medications.

For more information, visit **UrologyHealth.org/Download** or call 800-828-7866.

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