Voyage HEALTHCARE
~ Health Begins Here ~

Patient's Name: _____

Patient's Date of Birth: _____

Today's Date: _____

Health Risk Assessment – For Your Yearly Wellness Visit

Please complete this questionnaire before your Wellness Visit appointment scheduled for _____
Your responses will help you receive the best possible health care.

1. During the past 2 weeks, have you felt:

nervous, anxious, or on edge?	❑ *No*	❑ *Yes*
you are not able to stop or control worrying?	❑ *No*	❑ *Yes*

2. Do you have difficulty with your hearing? ❑ *No* ❑ *Yes*

3. Can you do the following activities on your own (without help from someone)?

Travel alone on bus or taxi, or drive a car	❑ *No*	❑ *Yes*
Shop for groceries and clothes	❑ *No*	❑ *Yes*
Housekeeping and laundry	❑ *No*	❑ *Yes*
Prepare meals for yourself	❑ *No*	❑ *Yes*
Manage your own money	❑ *No*	❑ *Yes*
Take your medications as directed by your Provider	❑ *No*	❑ *Yes*
Personal care needs such as eating, bathing, dressing, getting around the house	❑ *No*	❑ *Yes*

4. How often do you fasten your seat belt when you are in a car?
❑ *Always* ❑ *Most Often* ❑ *On Occasion* ❑ *Never*

5. During the past 4 weeks, how much physical pain have you had in general?
❑ *No Pain* ❑ *Mild Pain* ❑ *Moderate Pain* ❑ *Severe Pain*

6. During the past 2 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*

7. How often do you get the social and emotional support you need?
❑ *Always* ❑ *Most Often* ❑ *On Occasion* ❑ *Never*

8. How many hours of sleep do you usually get each night? _____*Hours per night*

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9. In the past 2 weeks, how often have you felt sleepy during the day?

❑ *Never* ❑ *On Occasion* ❑ *Frequently* ❑ *Always*

10. During the past 2 weeks, how much did you exercise?

_____*days a week* _____*minutes per day (on days when I exercised)*

11. How intense is your typical exercise?

❑ *I do not exercise*
❑ *Light (stretching, walking)*
❑ *Moderate (brisk walking)*
❑ *Heavy (jogging, swimming)*
❑ *Very Heavy (running, stair climbing)*

12. In general, would you say your health is:

❑ *Excellent* ❑ *Very good* ❑ *Good* ❑ *Fair* ❑ *Poor*

13. How confident are you in controlling and managing most of your health problems?

❑ *I do not have health problems* ❑ *Confident* ❑ *Somewhat Confident* ❑ *Not Confident*

14. How confident are you in managing your own medications?

❑ *I do not take medications* ❑ *Confident* ❑ *Somewhat Confident* ❑ *Not Confident*

_____ **Patient Signature**

_____ **Provider Signature**

_____ **Date**

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Please write your **CURRENT MEDICATIONS** below

Including prescription, over-the-counter, supplements, herbals, homeopathic, vitamins, etc.

❑ I do not take medications

MEDICATION NAME and DOSE	MEDICATION NAME and DOSE

Please write the names of the **PROVIDERS** that help manage your health

Cardiologist, eye doctor, foot doctor, urologist, etc.

❑ I do not see any other providers

PROVIDER'S NAME	SPECIALTY or CONDITION THEY TREAT

Please write the **HEALTH SERVICES** you currently receive

Home care, medical equipment, oxygen, etc.

❑ I do not use any other services

COMPANY NAME	SERVICE or EQUIPMENT