Family Practice Medical Group
OF SAN BERNARDINO, INC.

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Health Risk Appraisal

Your results will be kept strictly confidential.

General Information Today's Date: ____________

1. Name: _________________________________
2. Gender: Male Female
3. Date of Birth:
4. Are you pregnant? No Yes (Complete this form based on your health & lifestyle prior to becoming pregnant)
5. Height (without shoes): feet Inches
6. Weight (without shoes): pounds
7. What is your blood pressure: Systolic (top number) Diastolic (bottom number) Unsure
8. What is your total cholesterol level? (based on a blood test): Mg/dL Unsure

8a. If diabetic, what was your last A1C?

Health Related Behaviors

9. How would you describe your cigarette smoking habits?
   - I still smoke, Go to question 10
   - I used to smoke, Go to question 11
   - I never smoked, Go to question 12
10. I still smoke cigarettes per day, Go to question 12

11a. How long has it been since you smoked cigarettes on a fairly regular basis? years months

11b. What is the average number of cigarettes you smoked per day in the two years before you quit?
   - Less than 9
   - 10-15
   - 16-19
   - 20+

12. What other forms of tobacco do you smoke or use?
   - Pipe
   - Cigars
   - Smokeless Tobacco
   - None
13. How often do you use drugs or medication (including prescription drugs) which affect your mood or help you to relax?
   - Almost every day
   - Sometimes
   - Rarely or never
14. How many drinks of alcoholic beverages do you have in a typical week? (one drink = one beer, one glass of wine, one shot of liquor, or one mixed drink) _____ Drinks
15. How many times in the last month did you drive or ride when the driver had perhaps too much to drink? ____ Times last month
16. What percentage of the time do you usually buckle your safety belt when driving or riding?
   - 100%
   - 90-99%
   - 80-89%
   - Less than 80%

17. On average, how close to the speed limit do you usually drive?
Within 5 mph of the speed limit
6-10 mph over the speed limit
More than 10 mph over the limit
18. Each day, how many servings of foods do you eat that are high in fiber, such as whole grain bread, high fiber cereal, fresh fruits or vegetables? (serving size: 1 slice bread, ½ cup or 110 ml vegetables, 1 medium fruit, ¾ cup or 170 ml cereal)
5-6 servings/day
3-4 servings/day
1-2 servings/day
Rarely/never
19. Each day, how many servings of food do you eat that are high in cholesterol or fat such as fatty meat, cheese, fried foods, or eggs? (serving size: 3 ½ oz or 100g meat, 1 egg, 1 oz/slice or 28g cheese)
5-6 servings/day
3-4 servings/day
1-2 servings/day
Rarely/never
20. In the average week, how many times do you engage in physical activity (exercise or work which is hard enough to make you breathe more heavily to make your heart beat faster) and is done for at least 20 minutes? Examples include running, brisk
walking or heavy labor, e.g. chopping, lifting, digging, etc.
Less than 1 time/week
1 or 2 times/week
3 times/week
4 or more times/week
21. How many days per week do you get 30 minutes or more (for at least 10 minutes at a time) of light to moderate physical activity? Examples include walking, mowing (push mower), slow cycling.
Less than 1 time/week
1 or 2 times/week
3 times/week
4 or more times/week
22. How many hours of sleep do you usually get at night?
6 hours or less
7 hours
8 hours
9 hours or more
Quality of Life Indicators
23. In general, how strong are your social ties with your family and/or friends?
Very strong
About average
Weaker than average
Not sure
24. Have you suffered a personal loss or misfortune in the past year? (For example: a job loss, disability, divorce, separation, jail term, or the death of someone close to you)
Yes, two or more serious losses
Yes, one serious loss
No

25. During the past year, how much effect has stress had on your health?
- A lot
- Some
- Hardly any
- None

25a. Do you feel safe in your home?
- Yes
- No

Medical History & Self Care

26. Overall, how would you rate your health during the past 4 weeks?
- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor

27. During the past 4 weeks how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?
- Not at all
- Very little
- Somewhat
- Quite a lot
- Could not do physical activities

28. During the past 4 weeks, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?
- Not at all
- Very little
- Somewhat
- Quite a lot
- Could not do physical activities

29. How much bodily pain have you had during the past 4 weeks?
- None
- Very mild
- Mild
- Moderate
- Severe
- Very severe

29a. What Does Your Pain Feel Like?
- Throbbing
- Stabbing
- Shooting
- Dull
- Sore
- Sharp
- Pinching
- Cutting
- Aching
- Tingling

29b. How Does Your Pain Change with Time?

Continuous
Intermittent
Brief

29c. How Strong is Your Pain?

Mild
Discomforting
Distressing
Horrible
Excruciating

30. During the past 4 weeks, how much energy did you have?

Very much
Quite a lot
Some
A little
None

31.During the past 4 weeks, how much did your physical health or emotional problems limit your usual social activities with family and friends?

Not at all
A little bit
Some
Quite a lot
Could not do social activities

32. During the past 4 weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed, or irritable)?

Not at all
Slightly
Moderately
Quite a lot
Extremely

33. During the past 4 weeks, how much did personal or emotional problems keep you from doing your usual work, school, or other daily activities?

Not at all
Very little
Somewhat
Quite a lot
Could not do daily activities

34. In the past 12 months, how many times have you:

Visited a physician's office or clinic 0 1-2 3-5 6 or more
Gone to the emergency room 0 1-2 3-5 6 or more
Stayed overnight in a hospital 0 1-2 3-5 6 or more

35. When was the last time you visited a dentist? (date)
36. When is the last time you had your vision checked? (date)
37. When was the last time you had these preventative services or health screenings?

Colon cancer screen
- Less than 1 year
- 5-6 years ago
- 1-2 years ago
- 7 or more years ago
- 2-3 years ago
- Never
- 3-4 years ago
- Don't know

Rectal Exam
- Less than 1 year
- 5-6 years ago
- 1-2 years ago
- 7 or more years ago
- 2-3 years ago
- Never
- 3-4 years ago
- Don't know

38. Do you have: If you have currently, are you:

Allergies
Never In the past Have currently Taking medication
Under medical care

Anxiety
Never In the past Have currently Taking medication
Under medical care

Asthma
Never In the past Have currently Taking medication
Under medical care

Back Problems
Never In the past Have currently Taking medication
Under medical care

Cancer
Never In the past Have currently Taking medication
Under medical care

Chronic digestive disease (ulcers, colitis)
Never In the past Have currently Taking medication
Under medical care

Chronic headaches
Never In the past Have currently Taking medication
Under medical care

Chronic lung disease (bronchitis, emphysema)
Never In the past Have currently Taking medication
Under medical care

Chronic pain
Never In the past Have currently Taking medication
Under medical care

Depression
Never In the past Have currently Taking medication
Under medical care

Diabetes
Never In the past Have currently Taking medication
Under medical care
Heart problems
Never In the past Have currently Taking medication
Under medical care
High blood pressure
Never In the past Have currently Taking medication
Under medical care
High cholesterol
Never In the past Have currently Taking medication
Under medical care
Joint problems (arthritis, gout)
Never In the past Have currently Taking medication
Under medical care
Kidney/Bladder problems
Never In the past Have currently Taking medication
Under medical care
Osteoporosis
Never In the past Have currently Taking medication
Under medical care
Tetanus shot
Less than 1 year
5-6 years ago
1-2 years ago
7 or more years ago
2-3 years ago
Never
3-4 years ago
Don't know
Blood pressure
Less than 1 year
5-6 years ago
1-2 years ago
7 or more years ago
2-3 years ago
Never
3-4 years ago
Don't know
Cholesterol Less than 1 year
5-6 years ago
1-2 years ago
7 or more years ago
2-3 years ago
Never
3-4 years ago
Don't know

Skin problems

Never In the past Have currently Taking medication
Under medical care

Stroke

Never In the past Have currently Taking medication
Under medical care

Women Only

39. When was the last time you had these preventative services or health screenings?

Pap test

Less than 1 year
5-6 years ago
1-2 years ago
7 or more years ago
2-3 years ago
Never
3-4 years ago
Don't know

Mammogram Less than 1 year
5-6 years ago
1-2 years ago
7 or more years ago
2-3 years ago
Never
3-4 years ago
Don't know

Breast exam (by physician or nurse)

Less than 1 year
5-6 years ago
1-2 years ago
7 or more years ago
2-3 years ago
Never
3-4 years ago
Don't know

40. Have you had a hysterectomy operation?

Yes No

Personal Information

41. Current marital status:

Single (never married)
Married
Separated
Widowed
Divorced
Other

42. Race/Ethnicity (Check all that apply):

- Asian
- Black/African American
- Pacific Islander or Native Hawaiian
- American Indian / Native Alaskan
- Hispanic
- White / Caucasian
- Other

43. Highest level of education you have achieved:

- Some high school or less
- High school graduate
- Some college
- College graduate
- Post graduate or professional degree

Health Planning Questions

44. In the next 6 months, are you planning to make any changes to keep yourself healthy or improve your health?

Increase physical activity Yes No Don't know Not needed

Lose weight Yes No Don't know Not needed

Reduce alcohol use Yes No Don't know Not needed

Quit or cut down on smoking Yes No Don't know Not needed

Reduce fat/cholesterol intake Yes No Don't know Not needed

Lower blood pressure Yes No Don't know Not needed

Lower cholesterol level Yes No Don't know Not needed

Cope better with stress Yes No Don't know Not needed