HRA QUESTIONNAIRE

better weighs
to better health

Patient's Name _____
Date of Birth _____/_____/_____

Today's Date _____/_____/2023

1. **Do you require any help with the following: (Check if yes)**

_____ Bathing
_____ Dressing/Grooming
_____ Using the Toilet
_____ Feeding yourself
_____ Preparing Meals
_____ Managing Medications
_____ Grocery shopping
_____ Housework
_____ Handling finances
_____ Transferring yourself (ability to get in and out of bed or chair)
_____ Driving

If you require help for any of the above tasks, who helps you? _____
Does this person live with you? Yes_____ No_____

2. **Do you have any of the following at your home?**

_____ Throw Rugs
_____ Poor Lighting
_____Slippery Bath/Shower
_____ Clutter in the floor
_____ Smoke Alarms

3. **On a scale of 0-10, 0** *being no pain* **and 10** *being the highest pain level you have ever experienced*, **how would you rate your pain today?** (Circle One)

0 1 2 3 4 5 6 7 8 9 10

4. **Do you wear hearing aids?** Yes_____ No_____
5. **Do you have any difficulty hearing the TV or radio when others do not?**
   Yes _____ No _____ Sometimes _____
6. **Do you struggle to hear or understand when people are speaking to you?**
   Yes _____ No _____ Sometimes _____
7. **Do you have a Hearing Specialist?** Yes _____ No _____
   If yes, who is your Hearing Specialist? _____
8. **Do you have any issues with your speech?** Yes _____ No _____
9. **Do you wear glasses or contacts?** Yes _____ No _____
10. **Do you any current issues with your vision?** Yes _____ No _____
    If yes, what issues? _____
11. **When was your last eye exam?** _____/_____/_____
12. **Who is your eye care provider?** _____
13. **Do you often lose control of your urine?** Yes _____ No _____
    If yes, would you like more information on bladder control? Yes _____ No _____

better weighs
to better health

HRA QUESTIONNAIRE

Patient's Name _____
Date of Birth _____/_____/_____

14. **How would you describe your physical activity compared to last year?** (Circle One).
Better Same Worse

15. **Are you currently being treated for depression?** Yes_____ No_____
16. **During the past 2 weeks, have you been bothered by emotional problems, felt down, bothered, sad, downhearted, blue, or anxious?** Yes_____ No_____
17. **During the past 2 weeks, have you felt little interest or pleasure in doing things?**
Yes _____ No _____

18. **Have you fallen more than once in the past year?** Yes _____ No _____
19. **Have you had an injury as a result of a fall within the last year?** Yes _____ No _____
20. **How do you move around?**
_____ Walk independently *without* any assistance
_____ Walk independently **but, I feel weak or unsteady**
_____ Walk ***with assistance*** **of cane and/or walker**
_____ Wheelchair
21. **Are you afraid of falling?** Yes _____ No _____

22. **What is your marital status?** (Circle One) **Single Married Widowed Divorced**
23. **List everyone living in your household with you, including pets**:
1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

24. **Are you the primary caregiver for someone at home that depends on you for daily tasks?** Yes _____ No _____
25. **Do you or someone in your family need caregiver assistance information?**
Yes _____ No _____

26. **Do you use tobacco?** Yes _____ No _____ Formerly _____ (Quit Date _____)
If yes, what type? _____ **How much?** _____ **How often?** _____
If yes, are you interested in trying ways to quit? Yes _____ No _____

27. **On average, how many alcoholic drinks do you have per day?** _____

HRA QUESTIONNAIRE

Patient's Name _____
Date of Birth _____/_____/_____

28. **Have you had more than 4-5 drinks in a day in the past year?** Yes _____ No _____
29. **Are others concerned about your drinking habits?** Yes _____ No _____

30. **Do you use illicit (illegal) drugs?** Yes _____ No _____
    If yes, do you need more information on resources that offer assistance for addiction?
    Yes _____ No _____

31. **Do you have any issues with taking any of your medications as prescribed?**
    Yes _____ No _____
    If yes, what prevents you from taking your medications as directed? (ex. cost, forget)
    _____

32. **Have you had your flu shot this flu season?** Yes _____ No _____
    If so, where? _____ Approximate date, if known? ____/____/_____
33. **Have you ever had a pneumonia vaccine?** Yes _____ No _____
    If so, where? _____ Approximate date, if known? ____/____/_____

34. **Do you have an Advance Directive?** Yes _____ No _____ I'm not sure _____
    If <u>yes</u>, when was it updated? _____
    If <u>no</u>, may we discuss Advanced Care Planning with you today? Yes _____ No _____

    Do you have someone willing to make medical decisions on your behalf?
    If so, who? _____

35. **What is your top health goal for the next year?** _____
36. **Do you have any other social or financial issues that you would like to address?**
    _____
37. **Would you be interested in learning more about telephone access and monthly discussions with a Personal Health Coach that works closely with you and your provider to help meet your personal health goals and can assist you with community resources that may be available to you?** Yes _____ No _____

Date of Last Colonoscopy? _____ Results: _____

Women Only:

Date of Last Mammogram? _____ Results: _____

better weighs
to better health

HRA QUESTIONNAIRE

Patient's Name _____
Date of Birth _____/_____/_____

Please put a check mark by any of the following conditions that you have or have ever been diagnosed with:

Amputation _____

Cancer _____ Type: _____

COPD _____

Blood Clots _____

Depression _____

Diabetes _____

Eye Disease _____

Heart Attack _____

Heart Disease _____

Heartburn/Reflux _____

High Cholesterol _____

Kidney Disease _____

Lung Disease _____

Mental Illness _____ Type: _____

Stroke _____

Suicide Attempt _____

Please provide a list of current specialists that you have actively seen in the past 3 years and the type of specialty or list the condition that they were treating:

Name	Specialty