HMSA Akamai Annual Health Assessment Questionnaire

Patient Name:	Patient DOB:

About You	
1. Who do you live with?	☐ Alone ☐ With Spouse ☐ With other family member(s) ☐ With non-relative(s) ☐ Nursing home/assisted living facility

General Health/Prevention						
2. In the past 3 months, how many times did you go to the Emergency Room?	☐ 0 ☐ 1 ☐ 2 ☐ 3+					
3. In the past 6 months, how many times have you had unplanned overnight stays as a patient in a hospital?	☐ 0 ☐ 1 ☐ 2 ☐ 3+					
4. Have you had a flu shot this year?	☐ Yes ☐ No					
5. If you answered no, are you planning on receiving one this year?	☐ Yes ☐ No					
6. When was the last time you had a:	In the last year	In the last 2-4 years	In the last 5 years	In the last 10 years	Never	N/A
Pneumonia vaccine?	☐	☐	☐	☐	☐	☐
Prevnar 13?	☐	☐	☐	☐	☐	☐
Breast cancer screening (Mammogram)?	☐	☐	☐	☐	☐	☐
Colorectal cancer screening (Colonoscopy)?	☐	☐	☐	☐	☐	☐
Cervical cancer screening (PAP Smear)?	☐	☐	☐	☐	☐	☐
PSA?	☐	☐	☐	☐	☐	☐
Osteoporosis?	☐	☐	☐	☐	☐	☐
7. Do you have a Medical Power of Attorney? (Someone to make medical decisions for you in the event you are unable to).	☐ Yes ☐ No ☐ Don't remember/don't know					
8. Do you have a living will/advanced directive? (Documents that makes your health care wishes known)	☐ Yes ☐ No ☐ Don't remember/don't know					
9. Is a copy of your advanced directive on file at your PCP's office?	☐ Yes ☐ No ☐ Don't remember/don't know					

Exercise:	
10. How many days a week do you exercise?	☐ None ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
Sleep	
How many hours of sleep do you usually get?	☐ 0-3 ☐ 4-6 ☐ 7-10 ☐ 10+ ☐ I don't know
Tobacco Use	
Do you currently smoke, chew, or vape tobacco?	☐ Yes ☐ No ☐ Former Smoker
If you are a former smoker, how many years did you smoke?	☐ <5 ☐ 5-10 ☐ 10-15 ☐ 15-20 ☐ 25+
11. For current smokers, what products do you use? *(Check all that apply)*	☐ Cigarettes ☐ Chew ☐ Snuff ☐ Pipe ☐ Cigars ☐ Vape Cigarettes ☐ Vape Pen
12. Are you interested in quitting?	☐ Yes ☐ No
Alcohol Use	
13. How often do you have a drink containing alcohol?	☐ Never ☐ Monthly or less ☐ 2-4x/month ☐ 2-3x/week ☐ 4+ times a week

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14. How many standard drinks containing alcohol do you have on a typical day?	☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+
15. How often do you have 6 or more drinks on one occasion?	☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily/almost daily

Medication Usage	
16. How often do you take medications?	☐ Daily ☐ Weekly ☐ As needed ☐ Never
17. How many medications do you take?	☐ 0 ☐ 1-3 ☐ 4-5 ☐ 6-7 ☐ 8+
18. Do you find that sometimes you have to choose between buying groceries or medications?	☐ Yes ☐ No ☐ Sometimes

Fall Screening	
19. Have you had 2 or more falls within the past 12 months?	☐ Yes ☐ No
20. Have you had a fall with injury?	☐ Yes ☐ No
21. Do you have any problems with gait or balance?	☐ Yes ☐ No
Depression Screening	
22. In the past 2 weeks, have you had little interest or pleasure in doing things?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly everyday
23. In the past 2 weeks, have you been feeling down, depressed, or hopeless?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly everyday
Pain	
24. In the past 4 weeks, how much body pain have you had?	☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
25. In the past 4 weeks, how much did your pain interfere with your normal activities?	☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
26. During the past 4 weeks, how has your health impacted your ability to work or caused you to be absent from activities you enjoy?	☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
27. How do you treat the pain?	☐ Medication ☐ Rest ☐ Heat/Cold ☐ Therapy ☐ No treatment Plan ☐ Other ☐ No pain

Activities of Daily Living:					
28. Do you need any help doing the following? *(please mark yes or no by each activity)*					
Activity	Yes	No	*Activity*	Yes	No
Standing up from a sitting position?	☐	☐	Walking in the house?	☐	☐
Walking outside of the house?	☐	☐	Preparing a meal?	☐	☐
Eating a meal?	☐	☐	Getting dressed?	☐	☐
Bathing?	☐	☐	Using the toilet?	☐	☐
Managing Medications?	☐	☐	Shopping?	☐	☐
Organizing you day?	☐	☐	Driving or getting to places?	☐	☐
Using the telephone?	☐	☐	Doing laundry?	☐	☐
29. If you answered 'yes' to any of the above questions, do you have someone who can assist you?			☐ Yes ☐ No Caregiver Name/Relationship:		

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30. How often do you need to have someone hep you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
Ambulation Status:	
31. How long can you walk or move around?	☐ 0-5 min ☐ 5-15min ☐ 15-30min ☐ 30-60 min ☐ more than 1 hour
32. Which of these assistive devices do you use?	☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Other ☐ None
Sensory Abilities:	
33. Do you have problems with vision?	☐ Yes ☐ No ☐ Sometimes
34. Do you use eyeglasses or contact lenses?	☐ Yes ☐ No
35. Do you have problems with hearing?	☐ Yes ☐ No ☐ Sometimes
36. Do you have difficulty hearing when someone speaks in a whisper?	☐ Yes ☐ No ☐ Sometimes
37. Do you use hearing aids or other devices to help you hear?	☐ Yes ☐ No

Home/Safety:	
38. Please indicate which safety features you have installed in your home:	☐ Smoke alarm ☐ Carbon Monoxide Alarm ☐ Handles for shower/tub
39. Do you wear seatbelts when you ride in vehicles?	☐ Yes ☐ No ☐ I don't ride in vehicles
40. Please mark which of these you have in your house:	☐ Rugs ☐ Grab bars in bathroom ☐ Handrails ☐ Poor lighting
Social/Emotional Support:	
41. Which of the following applies to you:	☐ I have a supportive family ☐ I have supportive friends ☐ I participate in church, clubs, or other group activities ☐ None

Notes:
Indicate here any information that patient would like discussed with provider at AWV/AHA visit

Medications

Please list all medications in the boxes below

Name of Mediation	Strength	Frequency	Prescribing Physician

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Other Providers You See		
Specialty	Physician Name	Date Last Seen
Cardiologist		
Pulmonologist		
Eye Doctor		
Endocrinologist		
Dentist		
Dermatologist		
Gynecologist		
Ears, nose, and throat		

For Staff to complete only

Cognitive Assessment
Word Recall Score: ☐ 3/3 words ☐ 2/3 words ☐ 1/3 words ☐ no words
Clock Drawing: ☐ Passed ☐ Did not pass