

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date \_\_\_\_\_

## Detailed Health Assessment

Our clinic is working to achieve a recognition titled Patient Centered Medical Home. Patient-centered is a way of saying that you, the patient, are the most important person in the health care system. You are at the center of your health care. To provide the best quality care, it is important we keep information in your health record detailed and up-to-date.

Please fill out this questionnaire and provide your answers to a member of the Horizon Healthcare team for scanning to your medical record. Thank you for your time in completing this form. We appreciate you sharing your medical information with your medical home to enable us to provide the most comprehensive care to you, the center of our focus.

1. What is your age? \_\_\_\_\_
2. What is your marital status?  Single  Married  Divorced  Separated  Widowed
3. What is your race?(Check all that apply)  White  Black or African American  Asian  Hawaiian or other Pacific Islander  American Indian or Alaskan Native  Hispanic or Latino Origin  Other \_\_\_\_\_
4. Do you wear glasses or contact lenses?  Yes  No If yes, what kind? \_\_\_\_\_
5. Are you legally blind?  Yes  No
6. Do you have trouble hearing?  Yes  No
7. Do you wear a hearing aid?  Yes  No If yes, which ear?  Right  Left  Both
8. Do you have a Living Will, Power of Attorney for Healthcare, or a DNR?  Yes  No If yes what kind do you have and do we have a copy of it? \_\_\_\_\_
9. When was your last mammogram?  N/A Date: \_\_\_\_\_ If due, I decline   
What was the result of your mammogram?  Normal  Abnormal
10. When was your last Pap Smear?  N/A Date: \_\_\_\_\_ If due, I decline   
What was the result of your Pap Smear?  Normal  Abnormal
11. When was your last colonoscopy?  N/A Date: \_\_\_\_\_ If due, I decline   
What was the result of your Colonoscopy?  Normal  Abnormal
12. When was your last influenza shot? Date: \_\_\_\_\_ If due, I decline
13. When was your last pneumonia shot? Date: \_\_\_\_\_ If due, I decline

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14. If diabetic, when was your last diabetic eye exam?  N/A Date: \_\_\_\_\_ If due, I decline

What was the result of your diabetic eye exam?  Normal  Abnormal

15. During the past four weeks, how would you rate your overall health?  Excellent  Very Good  Good  
 Fair  Poor

16. During the past four weeks how much body pain have you had?  No Pain  Mild Pain  Moderate Pain  Severe Pain

17. How often in the past four weeks have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or Dizzy Upon Standing					
Sexual Problems					
Trouble Eating Well					
Teeth or Denture Problems					
Problems Using the Telephone					
Tiredness or Fatigue					

18. Due to any health problems you may have, do you need the help of another person to perform your personal care needs such as eating, bathing, dressing, or getting around the house?  Yes  No

19. How confident are you that you can control and manage most of your health problems?  Very confident  
 Somewhat confident  Not very confident  I do not have any health problems

20. How often do you have trouble taking medications the way you have been told to take them?  I always take them as prescribed  I sometimes take them as prescribed  I seldom take them as prescribed  I do not take any medications

21. During the past four weeks was someone available to help you if you needed and wanted help?  Yes, as much as I wanted  Yes, quite a bit  Yes, some  No, not at all

22. Can you go shopping for groceries or clothing without someone's help?  Yes  No

23. Can you prepare your own meals?  Yes  No

24. Can you manage your money without someone's help?  Yes  No

25. Do you have difficulties driving a car?  Yes, often  Sometimes  No  N/A I do not drive

26. Do you smoke?  Yes, but I would like to quit  Yes but I'm not ready to quit  No

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27. Are there smokers in the home?  Yes  No
28. During the past four weeks how many alcoholic beverages have you had?  None  10 or more per week  6-9 per week  2-5 per week  One drink per week (Example- wine, beer, hard liquor)
29. Do you drink or consume caffeine on a daily basis?  Yes  No
30. What is your occupation/job? \_\_\_\_\_ Where do you work? \_\_\_\_\_
31. What level of education did you complete?  GED  High School  Associates  Bachelors  Masters  
Other: \_\_\_\_\_
32. What type of house do you live in?  Single family  Multi-family  House  Trailer  Apartment
33. Do you exercise?  Yes  No Is yes, do you exercise for 20 minutes three or more days a week?  
 Yes, most of the time  Yes, some of the time  No
34. Do you have any religious preferences that affect your health care decisions?  Yes  No If yes, what are they \_\_\_\_\_
35. Do you have a fire/smoke alarm in the house?  Yes  No
36. Do you have a carbon monoxide detector/alarm in the house?  Yes  No
37. Is there Radon in the home?  Yes, treated  Yes untreated  No  Not tested
38. Have you fallen two or more times in the past year?  Yes  No If yes, how many times? \_\_\_\_\_
39. Are you afraid of falling?  Yes  No
40. Do you own firearms?  Yes  No If yes are they locked up for safety?  Yes  No
41. Do you have central heat/air conditioning?  Yes  No
42. If no central heat, what type of heat do you use?  Coal  Wood  Gas  Oil  Solar
43. What type of bed do you sleep on?  Box spring  Water bed  Foam  Allergy covered
44. What type of floors do you have?  Carpet  Hardwood  Tile/linoleum
45. Do you have pets in your home?  Yes  No If yes, what kind and how many? \_\_\_\_\_
46. During the past four weeks how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, downhearted, or blue?  Not at all  Slightly  Moderately  Quite a bit  Extremely
47. During the past four weeks has your physical and emotional health limited your social activities with your family and friends?  Not at all  Slightly  Moderately  Quite a bit  Extremely

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48. Do you have a history of recreational drug use?  Yes  No If yes, what kind? \_\_\_\_\_

49. Do you have suicidal thoughts?  Yes  No

50. Do you have homicidal thoughts?  Yes  No

51. Have you ever been or are you currently diagnosed with a mental disorder?  Yes  No If yes, type \_\_\_\_\_

52. What gender were you born?  Male  Female

53. What gender do you identify with?  Male  Female

54. What is your sexual interest?  Male  Female  Bi-Sexual

55. Do you use contraceptives?  Yes  No If yes, what type \_\_\_\_\_

56. Do you have a history of sexually transmitted infections?  Yes  No If yes, what type \_\_\_\_\_

57. What is your HIV status?  Negative  Positive  Untested

**Thank you for choosing Horizon Healthcare. Your care is important to us.**