2012 HRA Patient Questionnaire

MEMBER NAME: _____

GENDER: _____AGE: _____ DOB: _____

Race:

- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Native Hawaiian
- ☐ White
- ☐ Pacific Islander
- ☐ Other _____

Preferred Language:

☐ Hindi	☐**spoken**	☐ **written**
☐ English	☐**spoken**	☐ **written**
☐ Korean	☐**spoken**	☐ **written**
☐ Mandarin Chinese	☐**spoken**	☐ **written**
☐ Spanish	☐**spoken**	☐ **written**
☐ Russian	☐**spoken**	☐ **written**
☐ Other _____	☐**spoken**	☐ **written**

General health

1. In general, would you say your health is?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

2. How would you describe the condition of your mouth and teeth, including false teeth or dentures?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

3. In general, would you say your sexual health is?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

Alcohol Use

1. In the past 7 days, on how many days did you drink alcohol? ____ Days

2. On days when you drank alcohol, how often did you have 4 or more alcoholic drinks on one occasion?
   - ☐ Never
   - ☐ Once during the week
   - ☐ 2-3 times during the week
   - ☐ More than 3 times during the Week
   - ☐ Not applicable

3. Do you ever drive after drinking, or ride with a driver who has been drinking?
   - ☐ Yes
   - ☐ No

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Pain

1. In the past 7 days, how much pain have you felt?
   - ☐ None
   - ☐ Some
   - ☐ A lot

Physical Activity

1. In the past 7 days, how many days did you exercise? ____ Days

2. On days when you exercised, for how many minutes did you exercise? _____

3. How fast do you feel you walk?
   - ☐ Slow
   - ☐ Medium
   - ☐ Fast

4. Have you had any recent unintended weight loss?
   - ☐ Yes
   - ☐ No

5. Do you often feel exhausted?
   - ☐ Yes
   - ☐ No

6. How much energy do you feel you have?
   - ☐ Low
   - ☐ Medium
   - ☐ High

7. Do you often feel weak?
   - ☐ Yes
   - ☐ No

Sleep

1. Each night, how many hours of sleep do you usually get? _____ hours

2. Do you snore or has anyone told you that you snore?
   - ☐ Yes
   - ☐ No

Tobacco Use

1. In the last 30 days, have you smoked tobacco?
   - ☐ Yes
   - ☐ No

2. Do you use a smokeless tobacco product?
   - ☐ Yes
   - ☐ No

3. If yes to either question about tobacco use, would you be interested in quitting tobacco use within the next month?
   - ☐ Yes
   - ☐ No
   - ☐ Not applicable

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Nutrition

1. In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, ‰ cut of cooked vegetable, or 1 medium piece of fruit. 1 cup = size of a baseball.) _____servings per day

2. In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day? (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ‰ cut of cooked cereal such as oatmeal, or ‰ cut of cooked**brown** rice or whole wheat pasta.) _____ servings per day

3. In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day? _____

High Stress

1. How often is stress a problem for you in handling such things as your health, finances, family or social relationships, or work?
   - ☐ Almost all of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ Almost never

2. In the past 2 weeks, how often have you felt little interest or pleasure in doing things?
   - ☐ Almost all of the time
   - ☐ Most of the time
   - ☐ Almost never

3. Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?
   - ☐ Almost all of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ Almost never

4. In the past 2 weeks, how often were you not able to stop worrying or control your worrying?
   - ☐ Almost all of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ Almost never

5. In the past 2 weeks, how often have you felt angry?
   - ☐ Almost all of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ Almost never

6. In the past 7 days, how often have you felt sleepy during the daytime?
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never

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Depression

1. In the past 2 weeks, how often have you felt down, depressed, or hopeless?
   - ☐ Almost all of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ Almost never

Activities of Daily Living

1. In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?
   - ☐ Yes
   - ☐ No

   If yes, please describe:

_____
_____
_____

2. During the last 3 months, have you leaked urine (even a small amount)?
   - ☐ Yes
   - ☐ No

Instrumental Activities of Daily Living

1. In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, shopping, using the telephone, food preparation, transportation, or taking your own medications?
   - ☐ Yes
   - ☐ No

   If yes, please describe:

_____
_____
_____

Vaccinations:

1. Do you get a yearly flu shot?
   Yes ☐ No ☐

2. Have you had a pneumonia shot?
   Yes ☐ No ☐ If yes, when?
   _____

3. Have you had a shingles shot?
   Yes ☐ No ☐ If yes, when?
   _____

Social / Emotional Support

1. How often do you get the social and emotional support you need?
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Never

Anxiety

1. In the past 2 weeks, how often have you felt nervous, anxious, or on edge?
   - ☐ Almost all of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ Almost never

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Injury Risks

1. Do you live alone?
   Yes ☐ No ☐

2. Do you have stairs in your home?
   Yes ☐ No ☐

3. Do you have carpet flooring?
   Yes ☐ No ☐

4. Do you have area rugs?
   Yes ☐ No ☐

5. Do you ever feel unsteady when you walk?
   Yes ☐ No ☐

6. Do you feel dizzy or lightheaded?
   Yes ☐ No ☐

7. Have you ever fallen?
   Yes ☐ No ☐

8. What caused you to fall?
   _____
   _____

9. If you answered yes to question #7, do you fall often?
   Yes ☐ No ☐

10. Do you have smoke detectors in your home?
    Yes ☐ No ☐

11. Do you have carbon monoxide detectors in your home?
    Yes ☐ No ☐

12. Do you have animals in your home?
    Yes ☐ No ☐

13. Do you have firearms in your home?
    Yes ☐ No ☐

14. Do you drive?
    Yes ☐ No ☐

15. Do you wear seatbelts?
    Yes ☐ No ☐

16. Do you feel you can safely operate a car?
    Yes ☐ No ☐

14. Have you had a tetanus shot?
    Yes ☐ No ☐

15. If you answered yes to question #14 above, please provide the date you received the tetanus shot.
    _____

Patient signature _____ **Date** _____

For Office Use Only

HRA Initial ☐ **or Subsequent** ☐ **(please check one box)**

Reviewed by _____ **Date** _____