Health Risk Assessment Form

General

Name: ______________________
DOB: ____________ Gender: ____________
Height: ____________ Weight: ____________
Race: ______________________

Medical History

Date of last check-up: ______________
Allergies: ______________
Medications: ______________
Previous Medications: ______________
Injuries: ______________
Surgeries: ______________
Blood Pressure: ______________
Cholesterol: ______________

History of…

Cancer: ❑ Me ❑ Relation: ______________
Diabetes: ❑ Me ❑ Relation: ______________
Stroke: ❑ Me ❑ Relation: ______________
Heart Disease: ❑ Me ❑ Relation: ______________
Heart Attack: ❑ Me ❑ Relation: ______________
Depression: ❑ Me ❑ Relation: ______________
Bipolar Disorder: ❑ Me ❑ Relation: ______________

Females

Last date of most recent cycle: ______________
Date of last PAP Smear: ______________
Date of last breast exam: ______________
Date of last rectal exam: ______________
Year of last pregnancy: ______________
Did the pregnancy come to term? ❑ Yes ❑ No

Males

Date of last prostate exam: ______________

Well-Being

Rate your overall well-being: ❑ Great ❑ Good ❑ Fair ❑ Poor ❑ Bad

Rate your health: ❑ Great ❑ Good ❑ Fair ❑ Poor ❑ Bad

How safe do you feel? ❑ Very ❑ Not Very ❑ Not at all

How satisfied are you with your life? ❑ Very ❑ Not Very ❑ Not at all

How often do you feel depressed? ❑ Always ❑ Often ❑ Occasionally ❑ Never

Current therapist: ______________
Frequency of sessions: ______________
Starting date: ______________

Nutrition

How many daily servings of vegetables do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of fruit do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of grains do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of meat do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of sugar/carbs do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

Drug Use

How often do you smoke tobacco? ❑ Never ❑ Occasionally ❑ Often ❑ Daily ❑ Used to
How often do you chew tobacco? ❑ Never ❑ Occasionally ❑ Often ❑ Daily ❑ Used to
When did the tobacco use start? ______________
How many cigarettes do you have per day? ______________

How many alcoholic drinks do you have per week? ______________
How often do you binge drink (5+ drinks in 1 hour)? ❑ Occasionally ❑ Weekly ❑ Daily ❑ Never
Have you ever been treated for alcoholism? ______________
How often do you black out/lose time? ______________

Have you ever used recreational drugs? ______________
Which drugs? ______________
Have you ever abused prescription drugs? ______________
Which drugs? ______________
Have you ever been treated for drug use? ______________
How often do you use recreational drugs? ❑ Daily ❑ Weekly ❑ Often ❑ Occasionally ❑ Rarely ❑ Never

Exercise

How many days per week do you work on cardio? ______________
Length of time spent on cardio each session: ______________
How many days per week do you work on strength? ______________
Length of time spent on strength each session: ______________
Injuries/conditions that interfere with exercise: ______________

Other

Volunteer Activities: ______________
Who do you live with? ______________
Do you require…? ❑ Hearing Aid ❑ Walker ❑ Cane ❑ Oxygen Tank ❑ Glasses
How often do you get headaches? ______________
Food Sensitivities: ______________
How many hours of sleep do you get per night? ______________
How restful is your sleep? ❑ Restful ❑ I wake up once or twice ❑ I wake up often ❑ Fitful

www.FreePrintableMedicalForms.com