Premier HealthNet
Premier Health Partners
Fairfield Road Physician Offices

Personal Health Risk Appraisal

Today's Date: _____

Last Name: _____ **First Name:** _____ **MI:** ____

Address: _____
(Street Address) **(City)** **(State)** **(Zip)**

Birthdate: _____ **Age:** _____ **Marital/Partner Status:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Employer: _____ **Job Title:** _____

Do you have children? Yes _____ **No** _____ **If so, how many?** _____ **Ages?** _____

Do they live with you? Yes _____ **No** _____

Personal Health History
Check illnesses that you are experiencing, either currently or in the past. Give details on the back of this sheet:

Illness	Yes	Illness	Yes	Illness	Yes
Addictions		Alcoholism		Allergies	
Arthritis		Asthma/Hay Fever		Anemia/Blood Disorder	
Blood Transfusion		Broken Bones		Bowel Disease	
Chicken Pox		Constipation		Diarrhea	
Cancer (Describe type)		Cataracts		Chronic Bronchitis/Emphysema	
Chronic Cough		Chest Pain		Depression	
Diabetes		Deafness/Hearing Difficulty		Drug Abuse	
Epilepsy/Seizures		Ear/Nose/Throat Problems		Fainting/Dizziness	
Glaucoma		Gall Bladder Disease		Glasses/Contact Lens	
High Blood Pressure		High Blood Cholesterol		Hemorrhoids	
Head Injury		Hernia		Heart Disease	
Jaundice		Joint Problems		Kidney/Bladder Disease	
Mumps		Measles		Nervous/Emotional Disorders	
Rheumatic Fever		Sexually Transmitted Diseases		Skin Diseases	
Stroke		Tuberculosis (TB)		Ulcer/Stomach Trouble	
Venereal Disease (warts, herpes, HIV, syphilis)		Other (Describe):		Other (Describe):	

Description of Personal Health History (from front of sheet)

_____

_____

_____

_____

Family Health History
Check any disease which affected a member of your immediate family (parent, sibling, grandparent).
Specify which relative has or had the disease:

Illness	Yes	Which Relative?	Illness	Yes	Which Relative?
Alcoholism			Drug Abuse		
Nervous/Mental Disorder			High Blood Pressure		
Obesity			Lung Disease		
Heart Disease			Diabetes		
Stroke			Seizures		
Osteoporosis			Colon Cancer		
Breast Cancer			Ovarian Cancer		
Lung Cancer			Other Cancer		
Kidney Disease			Liver Disease		
Anemia/Blood Disorder			Prostate Cancer		
Colon Polyps			Other		

Current Symptoms/Health Concerns
Please describe any additional symptoms or concerns that you would like to discuss with your physician:

_____

_____

_____

Past Surgeries/Hospitalizations
List the dates and the reasons for hospitalization and/or type of surgery:

_____

_____

_____

Pregnancies
List number of pregnancies, vaginal or c-section, and any complications.

_____

_____

_____

Allergies
List all substances to which you have been told you are allergic. Include medications, dyes, environmental products, etc. What was the reaction to the allergen?:
_____

_____

_____

Current Medications
List all current medications. Include over-the-counter meds and herbal remedies:

Name of Medication	Dose	Time of day taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Personal Habits

What is your highest level of education (high school, college, trade school)
_____

If working, do you work full-time or part-time? FT _____ PT _____

Do you currently smoke tobacco? Yes _____ No _____

If so, how many cigarettes do you smoke each day? _____

If you smoked cigarettes in the past, when did you stop? _____

Describe any other tobacco use: _____

How many alcoholic beverages do you drink per day? _____ Per week? _____

Describe any drug use (not medications): _____ _____

Are you sexually active? _____ If yes, men, women, or both? _____

At what age did you become sexually active? _____

Number of sexual partners you have had in the past: _____

Do you practice "safe sex"? Yes _____ No _____

Do you have a Living Will (Advance Directive)? _____

Do you have a Durable Power of Attorney for Healthcare? If so, who is it? _____

Wellness

Complete the following statement: Overall, I would rate my health as (check one box):
Excellent _____ Very Good _____ Good _____ Fair _____ Poor _____

How many days per week do you engage in some form of aerobic exercise of at least 20 minutes duration (walking, biking, swimming, exercise class, other sports)? _____

What other types of physical activity do you engage in on a regular basis?
_____

If you are unable to be active on a regular basis, please describe the reasons why:
_____

Are you on a special diet? _____ Yes _____ No

If yes, what type of special diet? _____

Do you pay special attention to the following in your diet?	Yes	No
Fat intake		
Salt intake		
Increase in fruits and vegetables		
Increase in high fiber foods		

How many caffeinated beverages do you drink per day? _____

How much has your weight changed in the past year? Gain/Loss _____ lbs.

Coping and Stress

Overall, how well do you feel you are coping with life? _____

Please describe any symptoms you have that you feel are related to the stress in your life:

_____

What do you do on a regular basis to better cope with stress? _____

Personal Safety

Check the boxes that apply to you:	Yes	No
Do you wear a seatbelt every time you are in a car?		
Do you wear sun screen or protective clothing when you are in the sun?		
Do you have working smoke detectors in your home?		
Do you have a carbon monoxide detector in your home?		
Do others smoke in your home?		

Preventative Medical Care

Check the boxes that apply to you:	Yes	No	If yes, when/where?
Physical exam in past 5 years			
Cholesterol check in the past 2-5 years			
Blood pressure check in the past year			
Dental exam in the past year			
Vision exam in past 3 years			
Colon cancer screening in past 1-3 years (over age 50)			
Women:			
Pap smear exam in past 1-3 years			
Mammogram in past 1-2 years			
Breast self-exam monthly			
Bone density exam in past 2 years			
Men:			
Testicular self-exam monthly			
PSA (blood test for prostate cancer) in past 1-2 years			
Immunizations:			
Childhood immunizations (when you were young)			
Pneumonia vaccine			
Flu shot - yearly			
Hepatitis A vaccine (2 shots)			
Hepatitis B vaccine (3 shots)			
Tetanus/Diptheria every 10 years			
Adacel (Tetanus/Diptheria/Whooping Cough)			
Zostavax (Shingles vaccine)			

Health Interests

List any health/wellness topics for which you would like more information:

_____

_____

_____

Thank you for working with us to improve your health.

Physician signature _____ Date _____

Physician signature _____ Date _____

Physician signature _____ Date _____

(Revised 12/2007)