WHA Health Assessment

Demographics

Name:_____DOB:_____Date:_____

Gender: □ Male □ Female Height_____ Weight_____

Information provided by: □ Patient □ Caregiver □ Family Member □ Other: _____

Marital status? □ Single □ Married □ Separated □ Divorced □ Widowed □ Other _____

Living Situation? □ Alone □ with Family/Partner □ with Friends/Roommates □ Homeless □Board & Care

□ Group home □ other_____

Hospitalizations past 2 year (if any)? Please describe reason for hospitalization and date of occurrence:

_____

Emergency room visits past 2 years (if any)? Please describe reason for emergency room visit and date of occurrence:

_____

_____

Health History

1. In general, would your say your health is: □ Excellent □ Very good □ Good □ Fair
2. In general, how would you rate your overall mental health now? □ Excellent □ Very good □ Good □ Fair
3. In the past month have you been bothered by feeling down, depressed, or hopeless? □ yes □ no
4. Do you have or have you ever been diagnosed with any of the following health problems?

Arthritis, osteoarthritis or joint pain chronic pain	□ yes □ no
Asthma	□ yes □ no
Lung disease other than asthma (i.e chronic obstructive pulmonary disease [COPD], emphysema, chronic bronchitis)	□ yes □ no
Cancer- If yes Are you on treatment	□ yes □ no □ yes □ no
Chronic muscle/skeletal pain- chronic pain	□ yes □ no
Depression	□ yes □ no
Diabetes If yes- are you on insulin?	□ yes □ no □ yes □ no
Chronic Heart Failure	□ yes □ no
Heart disease (i.e, angina, heart attack, heart surgery, atrial fibrillation, etc)	□ yes □ no
Headaches (i.e migraines, or severe and/or frequent headaches	□ yes □ no
High blood pressure/hypertension	□ yes □ no
High blood cholesterol (or low HDL cholesterol	□ yes □ no
Allergies (seasonal or hay)	□ yes □ no
Anxiety disorder	□ yes □ no
Chronic fatigue or low energy	□ yes □ no
Digestive disorder (i.e irritable bowel ulcerative colitis, or Crohn's disease)	□ yes □ no
Overweight or obesity	□ yes □ no
Osteoporosis	□ yes □ no
Sleep disorder (sleep apnea, insomnia or other chronic sleeping problem)	□ yes □ no
Urinary or bladder problems	□ yes □ no

5. Do you have any other medical condition not listed above? If yes, please describe:

_____

6. Are you taking medication for any of the conditions listed above? □ yes □ no
7. Please list all current medications, including supplements and reason for taking it:

_____

_____

_____

Health Habits/ Safety

1. Do you exercise for about 20 mins on three or more days a week?
□ Yes, most of the time
□ Yes, sometimes
□ Not usually

2. How long has it been since your last physical exam by a physician?
□ Less than one year ago
□1-2 years ago
□ More than 2 years ago
□ Never
□ Don't know

3. How long has it been since your last dental check-up?
□ Less than one year ago
□1-2 years ago
□ More than 2 years ago
□ Never
□ Don't know

4. Do you smoke tobacco? □ yes □ no
If so, how many packs/week? _____
□ Never smoked
□ Former smoker, quit date _____
□ No, but live with a smoker
If so, how many packs/week? _____

5. On average how many alcoholic drinks do you have during a typical week? _____
(one drink is considered as 12 ounces of regular beer, 5 ounces of wine, 1.5 ounces of hard liquor)

6. Do you always fasten your seatbelt while in a car?
□ Always
□ Most of the time
□ Sometimes
□ Rarely or never

7. Have you fallen in the past year? □ yes □ no