

HMC FALL PREVENTION CLINIC HEALTH HISTORY QUESTIONNAIRE

The following is part of your medical record and will remain confidential.

IDENTIFICATION DATA (PLEASE PRINT) Today's date ____ / ____ / ____

Name _____

Address _____

Mailing or P O Box

City _____ State _____ Zip code _____

Phones Home _____ Work _____ Other _____

Gender Male Female Age _____ Date of Birth ____ / ____ / ____
MONTH DAY YEAR

Alternative Contact Name _____ Relationship _____ Phone _____

Which of the following best describes your residence (check one): Single family house
 Condo or apartment Live with other in their home, condo, or apartment
 Retirement facility Board and care / residential care facility
 Nursing home Other – specify: _____

Live with (check one): Spouse Parents Relatives Friends
 Alone Other: _____

What community support services do you use? Meals on Wheels ElderHealth NW
 In-home care (COPES) Senior Info & Assistance Access transportation
 Other: _____

Which one or more of the following would you say is your race?
 White Asian
 Black or African American American Indian or Alaska Native
 Native Hawaiian or other Pacific Islander Other _____
 Hispanic

FAMILY HISTORY Has any BLOOD RELATIVE had any of the following?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia or low blood	<input type="checkbox"/>	<input type="checkbox"/>	Heart attacks
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure (hypertension)

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FAMILY HISTORY (cont)		Has any BLOOD RELATIVE had any of the following?			
Yes	No	Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	Seizures, fits, epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer - of what? _____	Sickle cell anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dementia (such as Alzheimer's Disease)	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	High blood sugar (diabetes mellitus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding	Thyroid gland trouble (goiter)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fractures your mother had after age 50 (osteoporosis)	Tuberculosis (TB)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>			Hay fever, pollen allergies, eczema	

YOUR HEALTH HISTORY		Have YOU had any of the following?			
Yes	No	Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or low blood	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	Liver disease, yellow jaundice, or hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder infections, frequent	Brittle bones (osteoporosis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer - of what? _____	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	Rheumatoid arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Estrogen therapy If yes, <input type="checkbox"/> currently?	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Falls, balance issues	Seizures, fits, epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fractures of <input type="checkbox"/> hip <input type="checkbox"/> spine <input type="checkbox"/> wrist	Stroke
		<input type="checkbox"/>	<input type="checkbox"/>	Since age 45? How many? _____	High blood sugar (diabetes mellitus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	Thyroid gland trouble (goiter)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing difficulty needing hearing aid(s)	Tuberculosis (TB)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart failure	Vision problems - cataracts, glaucoma, macular degeneration
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart beat irregular (arrhythmia)	Uncontrolled bleeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	Venereal disease (VD)
<input type="checkbox"/>	<input type="checkbox"/>			Hernia	
<input type="checkbox"/>	<input type="checkbox"/>			High blood pressure (hypertension)	

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The following is part of your medical record and will remain confidential.

Do you have allergies (rash, hives, throat swelling, collapse) to any medications?

YES NO

If yes, please list the name of the medication(s), and the type of reaction(s) you have had:

Any other health issues not addressed above?

HEALTH HABITS

Do you drink alcohol, including beer, wine, or other alcohol (vodka, whiskey, or gin)? Yes No

Daily Almost daily (4 to 6 times a week) 1 to 3 times a week

Less than 1 time a week Never

If you drink alcohol, what kind? _____

Has anyone ever been concerned about your drinking?

No Yes

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The following is part of your medical record and will remain confidential.

HEALTH HABITS (cont.)

Have you ever smoked cigarettes?

No Yes -> If YES, are you now smoking?

No if not currently smoking:

How many years ago did you quit? _____ years

For how many years did you smoke? _____

How much did you smoke _____ packs per day

Yes if you are still smoking:

How many years have you smoked? _____ years

How much do you smoke _____ packs per day

How many meals do you generally eat each day? _____

How many glasses of water do you drink each day? _____

ACTIVITY AND EXERCISE

Please describe your daily activities (how do you spend your time?)

___ Place an X next to the alternative that best describes your present mobility:

- () I am able to walk normally (without difficulty) indoors, outdoors and on stairs.
- () I am able to walk without difficulty indoors, but outdoors and/or on stairs I have slight difficulties.
- () I am able to walk without difficulty indoors (with or without a cane or walker), but outdoors and/or on stairs only with considerable difficulty or with help from others.
- () I am able to walk indoors only with help from others.
- () I am completely bed-ridden and unable to move about.

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The following is part of your medical record and will remain confidential.

Rapid Assessment of Physical Activity

Physical Activities are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work, or transportation.

The following questions ask about the amount and intensity of physical activity you usually do. The intensity of the activity is related to the amount of energy you use to do these activities.

<p>Light activities</p> <ul style="list-style-type: none"> • your heart beats slightly faster than normal • you can talk and sing 	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  Walking Leisurely </div> <div style="text-align: center;">  Stretching </div> <div style="text-align: center;">  Vacuuming or Light Yard Work </div> </div>
<p>Moderate activities</p> <ul style="list-style-type: none"> • your heart beats faster than normal • you can talk but not sing 	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  Fast Walking </div> <div style="text-align: center;">  Aerobics Class </div> <div style="text-align: center;">  Strength Training </div> <div style="text-align: center;">  Swimming Gently </div> </div>
<p>Vigorous activities</p> <ul style="list-style-type: none"> • your heart rate increases a lot • you can't talk or your talking is broken up by large breaths 	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  Stair Machine </div> <div style="text-align: center;">  Jogging or Running </div> <div style="text-align: center;">  Tennis, Racquetball, Pickleball or Badminton </div> </div>

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The following is part of your medical record and will remain confidential.

How physically active are you? (Check one answer on each line)

Does this accurately describe you ?

RAPA 1	1	I rarely or never do any physical activities.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	2	I do some light or moderate physical activities, but not every week.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	3	I do some light physical activity every week.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	4	I do moderate physical activities every week, but less than 30 minutes a day or 5 days a week.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	5	I do vigorous physical activities every week, but less than 20 minutes a day or 3 days a week.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	6	I do 30 minutes or more a day of moderate physical activities , 5 or more times a day	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	7	I do 20 minutes or more a day of vigorous physical activities, 3 or more days a week.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

RAPA 2	3 = Both 1 & 2	1	I do activities to increase muscle strength , such as lifting weights or calisthenics, once a week or more.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		2	I do activities to improve flexibility , such as stretching or yoga, once a week or more.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

ID #: _____

Today's Date: _____

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The following is part of your medical record and will remain confidential.

SYMPTOMS Check the box if any of the following apply to you NOW or in the PAST.

NOW

STOMACH, INTESTINAL (continued)

- Constipation
- Blood in bowel movements
- Black bowel movements
- Hemorrhoids (piles)
- Trouble controlling bowels (incontinence of bowels)

NOW

URINARY

- Frequent urination
- Painful urination
- Bloody urine
- Trouble starting urine
- Urinate more than 2 times a night
- Trouble holding urine (incontinence of urine)

NOW

BONES, JOINTS, MUSCLES

- Back pain
- Neck pain
- Joint stiffness
- Joint pain
- Joint swelling
- Severe lack of strength
- Unsteadiness or balance problems when walking
- Fear of falling

NOW

NERVOUS SYSTEM

- Lack of energy
- Fainting spells (black outs)
- Tremor (shaking, trembling)
- Memory problems
- Paralysis
- Numbness (body parts "go to sleep")
- Nervousness
- Difficulty concentrating
- Depression (feeling blue)
- Crying spells
- Feelings of worthlessness
- Trouble getting along with people

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SYMPTOMS Check the box if any of the following apply to you NOW or in the PAST.

NOW

GENERAL

- Unexplained weight loss or gain
- Loss of appetite

NOW

SKIN

- Rashes
- Lumps
- Itching
- Dryness
- Color changes
- Changes in hair or nails

NOW

ENDOCRINE

- Excessive Sweating
- Excessive Thirst
- Excessive Hunger
- Large Urine Volumes

SYMPTOMS Check the box if any of the following apply to you NOW or in the PAST.

NOW

HEME/LYMPH

- Fatigue
- Night Sweats
- Sore Throat
- Chills
- Fever
- Abdominal Discomfort
- Swollen Glands

NOW

ALLERGIC

- Hoarseness
- Excessive Eye Watering/Tearing
- Nasal Congestion/Stuffiness
- Excessive Nasal Discharge

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Do you have a health problem these questions have missed? Yes No If yes, please list:

RATING OF HEALTH

In general, would you say that your health is:

Excellent Very Good Good Fair Poor

How confident are you in completing medical forms by yourself?

Extremely Quite a bit Somewhat A little bit Not at all

Over the last two weeks, how often have you been bothered by the following problems:

Little interest or pleasure in doing things

Not at all Several days More than half the days Nearly every day

Feeling down, depressed, or hopeless

Not at all Several days More than half the days Nearly every day

Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

_____ (number of days).

Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

_____ (number of days).

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

_____ (number of days).

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The following is part of your medical record and will remain confidential.

Which of the four statements below do you agree with most? Please check your answer.

I am intending to make changes to reduce my risk of falling in the next 6 months.

I am intending to make changes to reduce my risk of falling in the next month.

I have made changes to reduce my risk of falling in the next month.

I have made changes to reduce my risk of falling in the last 6 months.

I have not fallen for more than 6 months.

I don't agree with any of the above statements.

Signature of Patient or Patient's Legally Authorized Representative	Print Name	Date

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