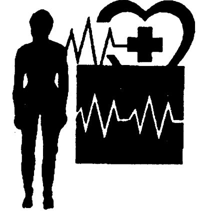
Name:
ID#:

ADULTS 21 and OLDER and ALL PREGNANT, POST PARTUM, BREASTFEEDING, and FAMILY PLANNING PATIENTS (ALL AGES)

RISK ASSESSMENT

If you have any questions or concerns about yourself, please share these with your health care provider. We want to assist you with your needs anyway possible.



YES	NO	
☐	☐	1. Are you physically active for a total of 30 minutes each day? Or if 50 years or older 20 minutes 3 times a week?
☐	☐	2. Do you have problems with activities of daily living, such as: making meals, shopping, bathing, or moving around?
☐	☐	3. Have you ever experienced feeling really down or depressed which lasted longer than a week?
☐	☐	4. Have you ever had thoughts about harming yourself?
☐	☐	5. Are you concerned that someone will harm you (or your child), or worry that you will harm someone?
☐	☐	6. Has your partner or someone important to you ever physically, verbally, or sexually abused you?
☐	☐	7. Do you smoke cigarettes, use smokeless tobacco, or use other tobacco products?
☐	☐	8. Have you ever used **(Circle all that apply)**:

Alcohol: Beer, Wine, Liquor
Drugs: Prescription (nerve, sleeping, or pain medicines)
Non - Prescription
Street Drugs (marijuana, cocaine, crack, or others)

YES	NO	
☐	☐	9. Have you ever felt you should cut-down on your drinking or drug use?
☐	☐	10. Do you examine your breasts (or testicles) monthly?
☐	☐	11. Do you have questions or concerns about sex or sexual orientation?
☐	☐	12. Are you sexually active? **(If NO and you are male, answer no further questions, if No and you are female skip to women only questions below.)**
☐	☐	13. Since beginning sexual relations have you had more than 1 partner? If yes, total number of partners _____.
☐	☐	14. Have you ever had a sexually transmitted infection/disease (STD or VD)? **(Circle all that apply):**

Gonorrhea	Chlamydia	Herpes
HIV/AIDS	Genital Warts or HPV	Syphilis

YES	NO	
☐	☐	15. Do you (or your partner) use condoms to protect against sexually transmitted infections?
☐	☐	16. Do you use any kind of birth control?
☐	☐	17. Have you ever been pregnant (or gotten someone pregnant)?

YES	NO	
☐	☐	18. Do you have concerns about your weight or eating habits?
☐	☐	19. Do you eat or drink every day **(circle all that apply):** Fried Foods Lunch Meats 4 or More Cups of Coffee Soft Drinks Cake Cookies Chips
☐	☐	20. Do you eat 6 servings of any of the following daily: Bread, Cereal, Rice, Pasta?
☐	☐	21. Do you eat 3 servings of vegetables daily?
☐	☐	22. Do you eat 2 servings of fruit or drink 2 serving(s) of 100% fruit juice daily?
☐	☐	23. Do you eat 2 servings of any of the following daily: meat (beef, pork, chicken, turkey), fish, soup beans, eggs, or peanut butter?
☐	☐	24. Do you eat 2 servings of any of the following daily: cheese, milk, or yogurt?
☐	☐	25. Do you have a special diet or are on a prescribed medication?

WOMEN ONLY

Childbearing Age:

☐	☐	1. Do you plan to give birth within the next year?
☐	☐	2. Have you been pregnant within the past 18 months?
☐	☐	3. Have you been pregnant 5 or more times?
☐	☐	4. Have you had a miscarriage in the last 18 months?
☐	☐	5. Have you ever had more than 2 miscarriages, an abortion, or surgery of the uterus or cervix?
☐	☐	6. Have you given birth to a baby weighing less than 5 ½ pounds, or more than 9 pounds?
☐	☐	7. Have you ever given birth to a stillborn baby, had a baby die before 12 months of age, or had a baby with birth defects?
☐	☐	8. Do you work with, or have you been exposed to chemicals, radiation, lead, and/or do you empty a cat's litter box?

Menopausal: (Gone through the change of life)

☐	☐	1. Do you have questions or concerns about menopause (change of life)?
☐	☐	2. Do you experience menopausal symptoms? **(Circle all that apply):** Hot Flashes Night Sweats Vaginal Dryness/Itching Painful Sex Mood Swings Change in Menstrual Periods
☐	☐	3. Since menopause have you experienced? **(Circle all that apply):** Vaginal Bleeding Abdominal Bloating Changes in Bowel Habits Changes in Your Breasts
☐	☐	4. Have you, your mother, or your daughter had breast cancer, osteoporosis (brittle bone disease), or cancer of the uterus, ovaries, or cervix?

QUESTIONS OR CONCERNS TO DISCUSS WITH YOUR HEALTH CARE PROVIDER:

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ENTIRE FORM HAS BEEN REVIEWED AND UPDATED ON FOLLOWING DATES:
(SIGNATURE AND DATE REQUIRED)

____________________ ____________________

____________________ ____________________