West Houston

Family Practice Associates

WEST HOUSTON FAMILY PRACTICE ASSOCIATES, P.A.

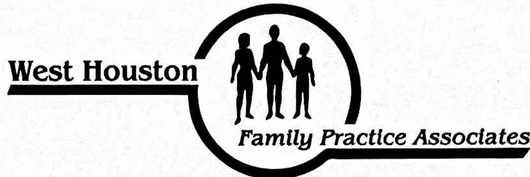
12245 Richmond Avenue
Houston, TX 77082-2518
(281) 558-6700

PCP: ____________________ Cigna HS? Yes No

Health Risk Assessment 2022 (COA)

Patient Name: ______________________________ DOB: ________________

Question				
Do you have an Advanced Directive?	☐ Y	☐ N		
Is it on file with us?	☐ Y	☐ N		
Over the past 2 weeks, have you often been bothered by feeling down, depressed, or hopeless?	☐ Y	☐ N		
Over the past 2 weeks, have you often been bothered by little interest or pleasure in doing things?	☐ Y	☐ N		
Does pain affect your daily activities?	☐ Y	☐ N		
Rate your pain on a scale of 0-10. 0=no pain and 10=worst pain: 0 1 2 3 4 5 6 7 8 9 10				
How often do you exercise?	Never	1-2/Week	2-3/Week	> 3/Week
How does your PHYSICAL health compare to last year?	Same	Better	Worse	
How does your MENTAL health compare to last year?	Same	Better	Worse	
Have you ever lost control of your urine?	No Problem	Small Problem	Major Problem	
Have you ever used tobacco?	Never	Former	Current	
What type:	How frequently?	For ________ years		
On average, how many alcoholic drinks to you have in a day?				
Have you had more than 4-5 drinks in a day in the past year?	☐ Y	☐ N		
Have you ever felt the need to cut down on your drinking?	☐ Y	☐ N		
Have people annoyed you by criticizing your drinking?	☐ Y	☐ N		
Have you ever felt guilty about drinking?	☐ Y	☐ N		
Have you ever felt you needed a drink first thing in the morning to steady your nerves or to get rid of a hang over?	☐ Y	☐ N		
What is your marital status?	Single	Married	Divorced	Widowed
With whom do you live?	Alone	Spouse	Family	Assisted
How often do you have sex?	Never	Sometimes	Frequently	
How many sex partners?	None	One and we are exclusive	One but s/he has others	2+
Do you have any social or financial concerns?	☐ Y	☐ N		
Did you have a fall within the past 3 months?	☐ Y	☐ N		



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Do you have problems with falling, walking steadily, or keeping balance?			☐ Y	☐ N
How do you move around?	I walk independently	I use a wheelchair	I am bed bound	
	I walk with a cane/walker	I walk but feel unsteady/need assistance		
Do you have difficulty with bathing or grooming?			☐ Y	☐ N
Do you have difficulty with eating or meal preparation?			☐ Y	☐ N
Do you have difficulty seeing?			☐ Y	☐ N
Do you require glasses/contacts for routine vision?			☐ Y	☐ N
Do you have hearing issues or require a hearing aid?			☐ Y	☐ N
Do you use illicit drugs?			☐ Y	☐ N

List any specialists you see regularly None ☐

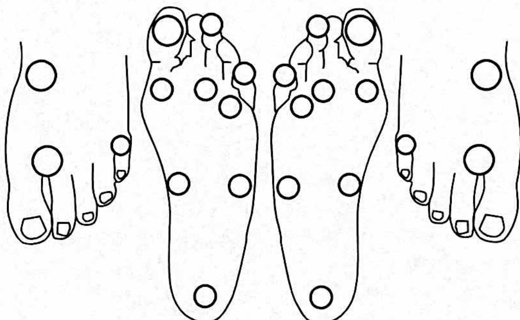
Doctor's Name	Specialty
1.	
2.	
3.	
4.	

Patient Signature: ______________________ Date: ______________

Physician Signature: ______________________ Date: ______________

Diabetic Foot Exam

Label the following sites to indicate patient responses to applications of monofilament vibration. Indicate presence (+) or absence (–) of sensory perception.



Loss of sensation?	No	R	L
Abnormal Foot Shape?	No	R	L
Foot Ulcer?	No	R	L
Edema?	No	R	L
Pedal pulses absent?	No	R	L

* ______________________
Sign here to verify completion of foot exam

MD DO NP PA ______________________
Circle credential above Date: ______________

POS Reorder # 1907582