UMPQUA HEALTH ALLIANCE

Adult Health Risk Screening

PLEASE PRINT

First Name, Last Name, Suffix	Date of Birth	Age
Mailing Address		
Phone Number	Email	

Race and Ethnicity

1. Which of the following describes your **racial** or **ethnic** identity? (Please check **all** that apply)

American Indian or Alaska Native ☐
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Mexican Native or Indio
- ☐ Central American, or South American

Black or African American ☐
- ☐ African American
- ☐ African (Black)
- ☐ Caribbean (Black)
- ☐ Other Black

Asian ☐
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino/a
- ☐ Laotian
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Middle Eastern/ North African ☐
- ☐ North African
- ☐ Middle Eastern

Native Hawaiian or Pacific Islander ☐
- ☐ Guamanian or Chamorro
- ☐ Micronesian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

White ☐
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other

Hispanic or Latino/a ☐
- ☐ Hispanic or Latino/a Central American
- ☐ Hispanic or Latino/a Mexican
- ☐ Hispanic or Latino/a South American
- ☐ Other Hispanic or Latino/a

Other Categories
- ☐ Other (please list) _____
- ☐ Don't know/ Unknown
- ☐ Don't want to answer/Decline

Languages

2. What is your preferred language?

Spoken: _____

Written: _____

3. Do you need **sign language** interpreter for us to communicate with you?

☐ Yes ☐ Don't know/Unknown

☐ No ☐ Don't want to answer/Decline

If yes, which type do you need? (ASL, PSE, tactile interpreting, etc.) _____

4. Do you need an **interpreter**?

☐ Yes ☐ Don't know/Unknown

☐ No ☐ Don't want to answer/Decline

5. How well do you **speak** English?

☐ Very Well ☐ Not at all

☐ Well ☐ Don't know/Unknown

☐ Not Well ☐ Don't want to answer/Decline

Health

6. Do any of the following apply to you? (please mark **all** that apply)

- ☐ Depression
- ☐ Breathing problems
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Alcohol Use
- ☐ Homeless
- ☐ Heart Failure
- ☐ Kidney Dialysis
- ☐ Smoking
- ☐ Drug Use
- ☐ Need Food

7. How many different **prescriptions** do you take each day?

☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ 11 or more

8. What is your **sexual** orientation? Do you **consider** yourself:

☐ Straight (heterosexual) ☐ Bisexual ☐ Decline to Answer
☐ Gay or Lesbian ☐ Asexual

9. How many family members, including yourself, do you currently have in your household? _____

10. What is your current work situation?

☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Work from Home
☐ Disabled ☐ Unemployed ☐ Other: _____

For the following questions, please mark **Yes**, **No**, or **Decline**.

	Yes	No	Decline
11. Are there any **cultural**, **religious**, or **spiritual beliefs** or **practices** that may influence your care?	☐	☐	☐
12. Are you **deaf** or do you have a really hard time hearing? If yes, at what age did this condition begin? _____	☐	☐	☐
13. Are you **blind** or do you have a really hard time seeing, even when wearing glasses? If yes, at what age did this condition begin? _____	☐	☐	☐
14. Do you have a really hard time **walking** or **climbing stairs**? If yes, at what age did this condition begin? _____	☐	☐	☐
15. Do you have a hard time **dressing** or **bathing**? If yes, at what age did this condition begin? _____	☐	☐	☐
16. Does a **physical**, **mental**, or **emotional** condition limit your activities in any way? If yes, at what age did this condition begin? _____	☐	☐	☐
17. Do you have a hard time **concentrating**, **remembering** or **making decisions** because of a **physical**, **mental**, or **emotional condition**? If yes, at what age did this condition begin? _____	☐	☐	☐
18. Do you have a hard time doing errands alone such as **visiting a doctor's office** or **shopping** because of a **physical**, **mental** or **emotional condition**? If yes, at what age did this condition begin? _____	☐	☐	☐
19. Do you have a hard time getting to **medical appointments** due to **needing a ride**?	☐	☐	☐
20. Do you have any **other** healthcare needs not listed in this survey?	☐	☐	☐

If you answered yes to question 20, please **explain your healthcare needs**:

_____

_____

_____