

Kuaj Txoj Kev Nojqab Haushuv

(Staying Healthy Assessment)

Tus Muaj Hnub Nyoog (Adult)

Tus menyuam lub npe (npe & xeem)	Hnub Yug	<input type="checkbox"/> Ntxhais <input type="checkbox"/> Tub	Hnub tim
Tus neeg uas ua daim ntawv no (yog tus neeg mob xav tau kev pab)	<input type="checkbox"/> Ib Tus Neeg hauv Tsevneeg <input type="checkbox"/> Lwm tus Qhia kom meej:	<input type="checkbox"/> Phoojywg	Puas xav tau kev pab txog daim ntawv no? <input type="checkbox"/> Xav <input type="checkbox"/> Tsis Xav

Thov koj teb cov lus nug ntawm daim ntawv no li uas koj teb tau. Khij vojvoos rau "Hla" yog koj tsis paub teb los yog koj tsis xav teb. Nco ntsoov nrog tus kws khomob tham yog koj muaj lus nug dabtsi txog tej yam uas hais hauv daim ntawv no. Koj cov lus teb yuav muab ceev cia tsis pub leejtwg pom li uas nws yog ib feem ntawm koj cov ntaub ntawv khomob.

Puas xav tau ib tug neeg txhais lus?
 Xav Tsis Xav

Clinic Use Only:
Nutrition

1	Koj puas haus lossis noj 3 pluag mov uas muaj calcium txhua hnub, xws li kua mis nyuj, cheese, yogurt, kua mis taum, lossis taum paj? <i>Drinks/eats 3 servings of calcium-rich foods daily?</i>	Noj <i>Yes</i>	Tsis Noj <i>No</i>	Hla <i>Skip</i>
2	Koj puas noj txiv hmab txiv ntoo thiab zaub txhua hnub? <i>Eats fruits and vegetables every day</i>	Noj <i>Yes</i>	Tsis Noj <i>No</i>	Hla <i>Skip</i>
3	Koj puas txo tau cov zaubmov kib lossis cov zaubmov fast food uas koj noj? <i>Limits the amount of fried food or fast food eaten?</i>	Tau <i>Yes</i>	Tsis Tau <i>No</i>	Hla <i>Skip</i>
4	Nws puas yoojyim rau koj mus nrhiav cov khoom noj txaus kom noj qab haus huv? <i>Easily able to get enough healthy food?</i>	Yooj Yim <i>Yes</i>	Tsis Yooj Yim <i>No</i>	Hla <i>Skip</i>
5	Koj puas haus ib poom dej soda, kua txiv hmab txiv ntoo, dej haus ua sports, lossis dej haus kom muaj zog yuav luag txhua hnub hauv ib lub lis piam? <i>Drinks a soda, juice/sports/energy drink most days of the week?</i>	Tsis Haus <i>No</i>	Haus <i>Yes</i>	Hla <i>Skip</i>
6	Koj puas niaj zaus noj zaubmov ntau dhau lawm lossis tsawg dhau lawm? <i>Often eats too much or too little food?</i>	Tsis Noj <i>No</i>	Noj <i>Yes</i>	Hla <i>Skip</i>
7	Koj puas muaj kev txhawj xeeb txog koj qhov kev hnyav? <i>Concerned about weight?</i>	Tsis Muaj <i>No</i>	Muaj <i>Yes</i>	Hla <i>Skip</i>
8	Koj puas muaj kev tawm dagzog (exercise) lossis siv sijhawm mus ua tej yam xws li mus taug kev, ua teb, ua luam dej ntev li ½ teev tauj ib hnub? <i>Exercises or spends time doing moderate activities for at least ½ hour a day?</i>	Muaj <i>Yes</i>	Tsis Muaj <i>No</i>	Hla <i>Skip</i>
9	Koj puas xav hais tias ntawm qhov chaw koj nyob puas muaj kev cobphum? <i>Feels safe where she/he lives?</i>	Xav <i>Yes</i>	Tsis Xav <i>No</i>	Hla <i>Skip</i>
10	Koj puas tau ua tsheb sib nraus tsis ntev tas los no? <i>Had any car accidents lately?</i>	Tsis Tau <i>No</i>	Tau <i>Yes</i>	Hla <i>Skip</i>

Physical Activity

Safety

11	Koj puas tau raug leejtwg ntaus, npuaj plhu, ncaws, lossis ua rau koj lub cev raug mob xyoo tas los no? <i>Been hit, slapped, kicked, or physically hurt by someone in the last year?</i>	Tsis Tau No	Tau Yes	Hla Skip	
12	Koj puas niaj zaus sia txoj siv zoj duav thaum koj tsav tsheb lossis caji tsheb? <i>Always wears a seat belt when driving or riding in a car?</i>	Sia Yes	Tsis Sia No	Hla Skip	
13	Koj puas khaws ib rab phom cia rau hauv koj lub tsev lossis ntawm qhov chaw uas koj nyob? <i>Keeps a gun in house or place where she/he lives?</i>	Tsis Khaws No	Khaws Yes	Hla Skip	
14	Koj puas txhuam hniav thiab siv txoj xov dig hniav txhua hnuv? <i>Brushes and flosses teeth daily?</i>	Txhuam Yes	Tsis Txhuam No	Hla Skip	Dental Health
15	Koj puas niaj zaus tu siab, tag kev cia siab li lawm, npau taws, lossis txhawjxeeb? <i>Often feels sad, hopeless, angry, or worried?</i>	Tsis Tu No	Tu Yes	Hla Skip	Mental Health
16	Koj puas pheej pw tsis tsaugzog? <i>Often has trouble sleeping?</i>	Tsis Pw No	Pw Yes	Hla Skip	
17	Koj puab haus lossis ntsuas luamyeeb? <i>Smokes or chews tobacco?</i>	Tsis Haus No	Haus Yes	Hla Skip	Alcohol, Tobacco, Drug Use
18	Koj puas muaj cov phoojywg lossis cov tibneeg hauv tsevneeg uas haus luamyeeb hauv koj tsev lossis hauv lub tsev uas koj nyob? <i>Friends/family members smoke in house or place where she/he lives?</i>	Tsis Muaj No	Muaj Yes	Hla Skip	
19	Xyoo tas los no, koj puas tau: <input type="checkbox"/> (txiv neej) haus tshaj 5 khob dej cawv tuaj ib hnuv? <input type="checkbox"/> (poj niam) haus tshaj 4 khob dej cawv tuaj ib hnuv? <i>In the past year, had (5 for men) or (4 for women) or more alcohol drinks in one day?</i>	Tsis Haus No	Haus Yes	Hla Skip	
20	Koj puas siv yeeb-tshuaj/tshuaj noj los pab kom koj pw tsaugzog, nyob kaj siab, nyob tswm, tsis txhob hnov mob qhov twg, lossis kom poob phaus? <i>Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?</i>	Tsis Siv No	Siv Yes	Hla Skip	
21	Koj puas xav hais tias koj lossis koj tus khub lub cev xeebtub lawm? <i>Thinks she/he or partner could be pregnant?</i>	Tsis Xav No	Xav Yes	Hla Skip	Sexual Issues
22	Koj puas xav hais tias koj lossis koj tus khub muaj ib yam mob vim nrog luag tej pw (STI), xws li Chlamydia, Gonorrhea, genital warts, lossis lwm yam? <i>Thinks she/he or partner could have a STI?</i>	Tsis Xav No	Xav Yes	Hla Skip	

23	Koj lossis koj tus khub puas tau pw uake ua niamtxiv nrog leejtwg yam tsis tau siv tshuaj noj los tivthaiv kom tsis txhob muaj me nyuam li xyoo tas los no? <i>She/he or partner(s) had sex without using birth control in the past year?</i>	Tsis Tau No	Tau Yes	Hla Skip	
24	Koj lossis koj tus khub puas tau pw nrog lwm tus tibneeg xyoo tas los no? <i>She/he or partner(s) had sex with other people in the past year?</i>	Tsis Tau No	Tau Yes	Hla Skip	
25	Koj lossis koj tus khub puas tau pw uake ua niamtxiv nrog leejtwg yam tsis tsis siv ib lub hnab looj txivneeg chaw xis xyoo tas los? <i>She/he or partner(s) had sex without a condom in the past year?</i>	Tsis Tau No	Tau Yes	Hla Skip	
26	Koj puas tau raug yuam lossis haub kom nrog lwm tus pw uake ua niamtxiv dua li? <i>Ever been forced or pressured to have sex?</i>	Tsis Tau No	Tau Yes	Hla Skip	
27	Koj puas muaj lwm lolus nug lossis kev txhawj xeeb txog koj txoj kev nojqab haushuv? <i>Any other questions or concerns about health?</i>	Tsis Muaj No	Muaj Yes	Hla Skip	

Other Questions

Yog muaj, thov qhia:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined the SHA
<input type="checkbox"/> Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Alcohol, Tobacco, Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature:	Print Name:		Date:		
SHA ANNUAL REVIEW					
PCP's Signature:	Print Name:		Date:		
PCP's Signature:	Print Name:		Date:		
PCP's Signature:	Print Name:		Date:		
PCP's Signature:	Print Name:		Date:		