**Health Risk Assessment Tool for Air Quality and Wildfire Exposure**

**Patient Information:**

* Name:
* Age:
* Gender:
* Contact Information:
* Date of Assessment:
* Assessed by (Nurse’s Name):

**Medical History:**

1. Do you have any of the following pre-existing conditions? (Check all that apply)
   * Asthma
   * Chronic Obstructive Pulmonary Disease (COPD)
   * Cardiovascular Disease
   * Diabetes
   * Allergies (specify):
   * Other respiratory conditions (specify):
   * Other chronic illnesses (specify):
2. Are you currently taking any medications?
   * Yes (List medications):
   * No
3. Have you experienced any of the following symptoms in the past week? (Check all that apply)
   * Cough
   * Shortness of breath
   * Wheezing
   * Chest pain or tightness
   * Eye irritation
   * Throat irritation
   * Fatigue
   * Dizziness
   * Headache
   * Other (specify):

**Exposure Assessment:**

4. How often have you been exposed to smoke or poor air quality in the past week?

* Rarely (1-2 days)
* Occasionally (3-4 days)
* Frequently (5-7 days)

1. How much time do you spend outdoors each day?
   * Less than 1 hour
   * 1-3 hours
   * 3-5 hours
   * More than 5 hours
2. Do you have access to air purification measures at home? (e.g., air purifiers, HVAC systems)
   * Yes
   * No
3. Do you know the air quality index (AQI) levels in your area?
   * Yes (Specify AQI range if known):
   * No

**Risk Factors:**

8. Are you or any household members part of a vulnerable population? (Check all that apply)

* Children under 12
* Elderly (65+)
* Pregnant women
* Individuals with compromised immune systems

**Environmental Factors:**

9. Do you live in an area that has been directly affected by wildfires recently?

* Yes
* No

10.Are there any other environmental factors affecting your health? (e.g., industrial pollution, allergens)

* + Yes (Specify):
  + No

**Behavioral Factors:**

11. Do you smoke or use tobacco products?

* Yes
* No

1. Do you engage in any activities that could increase exposure to smoke or poor air quality? (e.g., outdoor exercise, manual labor)
   * Yes (Specify):
   * No

**Protective Measures:**

13. What steps are you taking to protect yourself from poor air quality? (Check all that apply)

* Staying indoors
* Using air purifiers
* Wearing masks (e.g., N95)
* Reducing physical activity
* Monitoring AQI levels
* Other (specify):

**Assessment and Recommendations:**

* **Risk Level (Low/Moderate/High):**
* **Recommendations:**
  + Avoid outdoor activities during poor air quality days.
  + Use air purifiers at home.
  + Wear protective masks when going outside.
  + Regularly monitor AQI levels.
  + Seek medical attention if symptoms worsen.
  + Follow up with primary healthcare provider for further evaluation.

**Nurse’s Notes:**

* Additional observations or concerns:
* Follow-up appointment scheduled for:
* Patient education provided (Yes/No):