Health Risk Assessment

Please answer the questions below and return this Health Risk Assessment (HRA) to HealthTeam Advantage using the enclosed prepaid envelope. You can also complete the HRA online at HealthTeamAdvantage.com. Your responses help us better understand your healthcare needs so we can help you reach your goals.

Completion of this health questionnaire is required for HMO CSNP members and voluntary for PPO members. Responses will not affect your benefits in any way. Results may be shared with your primary care provider and care management team.

Member Name: _____

Member ID Number or Medicare Number: _____

Date of Birth: _____ **Phone:** _____

Email: _____

Preferred method of communication: _____ **Phone** _____ **Email**

Preferred time to contact me: _____ **Morning** _____ **Afternoon** _____ **Evening**

Race /Ethnicity

____ White ____ Black/African American ____ Native American

____ Asian or Pacific Islander ____ Hispanic/Latino ____ Multi-ethnic

Other _____

Height _____ ft _____ in **Weight** _____ lbs

In the previous 12 months, how many times have you seen your primary care provider?

____ None

____ One time

____ 2-3 times

____ 4 or more times

____ I don't have a primary care provider.

I use the following locations for my medical care:

Primary Care Provider ____ Yes ____ No

Specialist ____ Yes ____ No

Urgent Care ____ Yes ____ No

Emergency Room ____ Yes ____ No

In the previous six months, have you been to the emergency room four or more times?

____ Yes ____ No

In the previous six months, have you been admitted to the hospital more than twice?

____ Yes ____ No

In the previous six months, have you fallen more than twice?

____ Yes ____ No

Do you use any of the following to be safe moving and walking?

____ Cane ____ Walker ____ Scooter

____ Wheelchair ____ Ramp

Have you designated someone to make medical decisions if you can't? (Medical Power of Attorney)

____ Yes ____ No

Do you have a living will or advance directives?

____ Yes ____ No

Would you like information on a living will or advance directive?

____ Yes ____ No

Do you have any of the following conditions? Check all that apply.

Diabetes	____ Yes	____ No	Heart Attack	____ Yes	____ No
Heart Disease	____ Yes	____ No	High Blood Pressure	____ Yes	____ No
Congestive Heart Failure	____ Yes	____ No	Atrial Fibrillation	____ Yes	____ No
Lung Problems	____ Yes	____ No	Memory Loss/Dementia	____ Yes	____ No
Stroke	____ Yes	____ No			

Does one of your medical conditions significantly overwhelm your ability to take care of yourself?

_____ Yes _____ No

Do you have trouble obtaining food on a frequent basis?

_____ Yes _____ No

Do you need assistance with the following? Check one response for each task.

Task	Able to do this without help.	I have some help with this.	I need help and I have no one to help me.
Bathing			
Dressing			
Eating			
Using the restroom			
Walking			
Taking medications			
Meal preparation			
Housekeeping chores			
Shopping and errands			
Transportation			
Money management			

If you smoke, are you thinking about quitting smoking? Would you be interested in receiving some information?

_____ Yes _____ No _____ I don't know

Do you take more than 10 medications?

_____ Yes _____ No

Do you sometimes go without your medications due to cost?

_____ Yes _____ No

Do you have difficulty getting to the pharmacy to pick up your medications?

_____ No

_____ Sometimes

_____ Most of the time

_____ Always

If you want to share any personal health goals or concerns, please list or describe below.

_____

_____

_____

_____

_____

_____

IF you have DIABETES, please complete SECTION 2.

IF you have CONGESTIVE HEART FAILURE, please complete SECTION 3.

IF you have BOTH, please complete SECTIONS 2 AND 3.

SECTION 2: Diabetes

1. Which type of medication do you take for your diabetes? (check one)

_____ None
_____ Pills only
_____ Insulin only
_____ Both pills and insulin
_____ Other medicine by shot
_____ Pills, insulin, and other medication by shot

2. How often do you have your blood HgbA1c checked? (check one)

_____ Never
_____ Once a year
_____ Two or more times a year
_____ I don't know what HgbA1c is.

3. What was your last HgbA1c result? (check one)

_____ 6.5 or less
_____ Between 6.6 and 7.5
_____ Between 7.6 to 9.0
_____ More than 9.0
_____ Don't know

4. Do you have a glucometer (blood sugar testing device)?

_____ Yes _____ No

5. How many times do you check your blood sugar each day? (check one)

_____ Once
_____ Twice
_____ Three times
_____ Four or more times
_____ Less than daily
_____ Never

6. During a week, how often does your blood sugar drop below 70? (check one)

_____ Never
_____ Once
_____ Two or three times a week
_____ More than three times a week
_____ Don't know

7. How often do you have your feet checked? (check one)

_____ Once a year
_____ Twice a year
_____ Never

8. How often do you have an eye exam? (check one)

_____ Once a year
_____ Never

9. How often do you have your urine checked? (check one)

_____ Once a year
_____ Twice a year
_____ Never

SECTION 3: Congestive Heart Failure

1. Do you ever have difficulty walking or climbing stairs due to breathing? (check one)

_____ No
_____ Rarely
_____ Usually
_____ Always

2. How many pillows do you use to sleep at night? (check one)

_____ 1
_____ 2
_____ 3
_____ I can't sleep in a bed due to my breathing.

3. In the past month, how often are you short of breath? (check one)

_____ Several times a day
_____ Once daily
_____ A few times a week
_____ Not at all

4. How often do you weigh yourself at home? (check one)

_____ Daily
_____ Twice a week
_____ Never
_____ I don't have a scale.

5. Are you on fluid restriction? (check one)

_____ No
_____ Yes
_____ Yes, but I don't follow it.
_____ Why do I need to worry about fluid amounts?

6. Do you ever have swelling in your ankles or legs? (check one)

_____ No
_____ Rarely
_____ Usually
_____ Always

7. Do you watch the salt you use to cook or how much you eat? (check one)

_____ Yes
_____ Sometimes
_____ No
_____ Why do I have to worry about salt?

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