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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.

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I use the following locations for my medical care:

Primary Care Provider	____ Yes	____ No	Urgent Care	____ Yes	____ No
Specialist	____ 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.

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

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We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
FOOD		
Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
HOUSING/ UTILITIES		
Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
Are you worried about losing your housing?		
Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
TRANSPORTATION		
Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
INTERPERSONAL SAFETY		
Do you feel physically or emotionally unsafe where you currently live?		
Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by anyone?		
Within the past 12 months, have you been humiliated or emotionally abused by anyone?		

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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

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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?

Please return this Health Risk Assessment to HealthTeam Advantage using the enclosed prepaid envelope.

HealthTeam Advantage, a product of Care N' Care Insurance Company of North Carolina, Inc., is a PPO and HMO Medicare Advantage plan with a Medicare contract. Enrollment in HealthTeam Advantage depends on contract renewal.