



# Health Risk Assessment Form

MEMBER NAME: \_\_\_\_\_ MEMBER ID #: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

**HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE THESE:**

Alzheimer's Disease/Dementia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Amputation	<input type="checkbox"/> YES	<input type="checkbox"/> NO	High Cholesterol/Triglycerides	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HIV or AIDS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Arthritis or pain joints	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Kidney Disease and/or Dialysis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Birth Defects or Conditions (cerebral palsy, congenital disease, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Liver Disease, Cirrhosis or Hepatitis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Lung Disease (Emphysema, COPD)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	LUPUS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Depression/Mental Illness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Multiple Sclerosis or any paralysis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Epilepsy/Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Organ Transplant (liver, kidney, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sickle Cell Disease or Anemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hemophilia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**PLEASE ANSWER THESE QUESTIONS:**

Are your childhood immunizations (shots) up to date?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you need help getting transportation for your doctor visits or tests?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
In the past year have you felt sad or down for more than 2 months?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you ever feel in trouble or that you are being physically, mentally or sexually abused?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
In the previous 3 months, have you had difficulty meeting your living expenses?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you seen a dentist in the past 12 months?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any tooth pain or bleeding from your gums?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you lost or gained more than 10 pounds in the last 6 months without trying?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you pregnant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If "Yes", what is the date you are expected to deliver?		
Are you currently receiving WIC?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you receiving Services from the Healthy Start Program?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you started the process for your newborn baby to be enrolled with Medicaid?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you had a baby within the past 2 months?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Would you like information on Family Planning?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Would you like information on Teen Pregnancy Prevention?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you need help with any of the following: bathing, dressing, eating, walking, etc.?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you socialize with others regularly?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you foresee your health as getting a lot worse in the next 6 months?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you find that you have become more forgetful than you used to be?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you been to an Emergency Room or Hospitalized within the last 90 days?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you now have any medical equipment (like a wheelchair, aerosol machine, oxygen, etc.) that was given to you by a previous insurance company or Medicare/Medicaid?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If "YES", which one do you now have?		

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# Health Risk Assessment Form

<b>CONTINUED FROM FRONT OF PAGE</b>	
Do you smoke?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If "YES", would you like to get information to help you to stop smoking?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you think you have a problem with drinking alcohol or drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If "YES", would you like to get help with this problem?	<input type="checkbox"/> YES <input type="checkbox"/> NO
When was your last flu shot? <input type="checkbox"/> Never <input type="checkbox"/> Within the past 18 months <input type="checkbox"/> More than 18 months	
When was your last eye exam (with dilated pupils)? <input type="checkbox"/> Never <input type="checkbox"/> Less than 12 months ago <input type="checkbox"/> More than 12 months ago	
How many different medications do you take every day? <input type="checkbox"/> None <input type="checkbox"/> 1 to 3 <input type="checkbox"/> 4 to 6 <input type="checkbox"/> More than 6	
If you now have pain, please tell us how bad the pain is, with 1 being very little pain, 5 being medium pain, and 10 being very bad pain: <input type="checkbox"/> I have no pain <input type="checkbox"/> 1 to 3 <input type="checkbox"/> 4 to 6 <input type="checkbox"/> 7 to 10	
Who do you live with: <input type="checkbox"/> Alone <input type="checkbox"/> Spouse/Significant Other <input type="checkbox"/> Family/Friends <input type="checkbox"/> Shelter <input type="checkbox"/> Assisted Living Facility/Nursing Home <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____	

Please sign and date on the line below. Return this form to us in the stamped envelope or call Member Services toll free at **1-800-514-4561 (TTY 711)** if you need help completing this form.

DATE OF BIRTH: \_\_\_\_\_  MALE  FEMALE

CURRENT ADDRESS:

STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_ CELL PHONE OR OTHER PHONE NUMBER: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

YOUR PRIMARY LANGUAGE IS:  ENGLISH  SPANISH  OTHER (Specify) \_\_\_\_\_

\_\_\_\_\_  
 PRINT NAME/SIGNATURE OF PERSON COMPLETING THIS FORM

\_\_\_\_\_  
 RELATIONSHIP TO THE MEMBER? (e.g., Self, Spouse, etc.)