

Health Assessment

—Confidential—

The following information will be held confidential and will help us assess and accommodate your particular health care needs.

YOUR PERSONAL INFORMATION

Name _____ Date _____

Address _____

City, State, Zip _____

County _____ Home Phone _____

Date of Birth _____ Alternate Phone _____

Primary Care Physician _____ Pharmacy _____

Primary Care Physician's Address _____

Primary Care Physician's Phone _____

Please list any other doctor, and their specialty, who you see on a regular basis. _____

What is your primary language? English Other _____

Care Management is a comprehensive program, provided by a professional, to assist our membership. These services include, but are not limited to disease and health education, resources, and information in related areas. If available, are you interested in one of our care managers calling you? Yes No

IN CASE OF EMERGENCY, WHO MAY WE CONTACT?

Name _____ Relationship _____

Home Phone _____ Alternate Phone _____

Is your Emergency Contact also your legal *Power of Attorney*? Yes No

If no, would you like the person listed above to be allowed to correspond on your behalf, regarding your healthcare information?
 Yes No

May we leave messages regarding your healthcare on your home answering machine or voice mail at your home phone number?
 Yes No

YOUR MEDICAL HISTORY

1. Are you **currently** being treated for any of the following conditions? *(Please check all that apply.)*

- Diabetes: If yes, do you use insulin? Yes No
- Congestive Heart Failure
- COPD
- Asthma
- Mental Illness
- Other _____
- Cancer: Type _____
- High Blood Pressure
- Coronary Artery Disease
- Transplant (past/future intent)
- AIDS/HIV

2. Are you **currently** using any special treatments or home medical equipment? *(Please check all that apply.)*

- Oxygen
- Tracheostomy care
- Tube feedings
- Home** Speech/Occupational Therapy
- Home** Physical Therapy
- Home** Health Aide
- Other _____
- Nebulizer
- Catheter care
- Medic Alert
- Walker/cane
- Social Worker
- Insulin Pump
- CPAP/Bi-PAP machine
- Ostomy/wound care
- Wheelchair
- Hospital bed
- Visiting Nurse Services
- Chemotherapy

Name of current provider(s) of service/equipment? _____

Phone number(s)? _____

3. List prescriptions and medicine you are **currently** taking: *(use an additional sheet if needed)*

Medicine Name and Dosage

Medicine Name and Dosage, cont.

_____	_____
_____	_____
_____	_____
_____	_____

4. In the **past 90 days** have you received any of the following health care services? *(Please check all that apply.)*

- Inpatient hospital stay
- Skilled Nursing Facility
- Emergency room visit
- Convalescent facility
- Rehabilitation inpatient stay
- Other _____

5. In the **past 12 months**, how many times have you:

	1-2	3-5	6 or more
Seen your doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been to an Emergency Room?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been admitted to the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been admitted to a Skilled Nursing facility/inpatient rehabilitation center?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Do you **currently** receive help in any of the following areas? *(Please check all that apply.)*

- Administering medications
- Money management/bill payment
- If so, who helps you? _____
- Daily self-care
- Cooking
- Shopping
- Transportation
- Housework
- Making appointments

7. Compared to other persons your age, how would you rate your health? *(check one)*

- Excellent
- Good
- Fair
- Poor

8. What is your **current** living status? *(check one)*

- Live alone
- Live with spouse/significant other
- Live with children(s)
- Live with other relatives

9. Is there anything else you would like us to know about you? _____
