healthteam advantage℠ | Local. Reliable. Accessible.

HealthTeam Advantage Member Health Questionnaire

Please complete the Health Risk Assessment form and return it at your earliest convenience. You can also complete this questionnaire online at HealthTeamAdvantage.com. This questionnaire helps us fully understand your needs and overall better serve you.

Member Name: _____

Member ID Number or Medicare Number: _____ Date of Birth: _____

Phone: _____

Email: _____

Best Method to Communicate with me is: _____ Phone _____ Email

Best Time to Reach Me is: _____ Morning _____ Afternoon _____ Evening

Instructions: Please answer the questions below and return this questionnaire to HealthTeam Advantage. Completion of this health questionnaire is voluntary and will not affect your benefits in any way. Results may be shared with your primary care physician and may be used by the HealthTeam Advantage health assessment team.

Race /Ethnicity

____ White ____ Black/African American ____ Native American

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

Other _____

Your Height _____ ft _____ in **Current Weight** _____ lbs

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

____ None

____ One time

____ 2-3 times

____ 4 or more times

____ I don't have a Primary Care Physician

I use the following locations for my medical care

PCP ____ Yes ____ No

Specialist ____ Yes ____ No

Urgent Care ____ Yes ____ No

Emergency Room ____ Yes ____ No

In the previous 6 months, have you gone to the Emergency Room 4 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

Diabetes ____ Yes ____ No

Heart Disease ____ Yes ____ No

Congestive Heart Failure ____ Yes ____ No

Lung Problems ____ Yes ____ No

Stroke ____ Yes ____ No

Heart Attack ____ Yes ____ No

High Blood Pressure ____ Yes ____ No

Atrial Fibrillation ____ Yes ____ No

Memory Loss/Dementia ____ Yes ____ No

Do you have any of the following conditions? Check all that apply.
Does one of your medical conditions significantly overwhelm your ability to take care of yourself?

____ Yes ____ No Which condition? _____

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 these	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 and interested in receiving some information?

____ Yes ____ No

____ I do not smoke

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 A1C checked? (check one)

____ Never
____ 1 time a year
____ 2 or more times a year
____ Don't know what this 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. On a daily basis, how often do you check your blood sugar? (check one)

____ 1 time
____ 2 times
____ 3 times
____ 4 times or more
____ Less than daily
____ Never

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

____ Never
____ 1 time a week
____ 2-3 times a week
____ More than 3 times a week
____ Don't know

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

____ 1 time a year
____ 2 times a year
____ Never

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

____ 1 time a year
____ Never

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

____ 1 time a year
____ 2 times 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 1 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 weight 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?