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HealthTeam Advantage 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 voluntary for PPO members and required for HMO members. Your 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 gone 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 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

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 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 and are you 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 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?