GlobalHealth
Medicare Advantage Plans
Attn: Care Management (HRA)
P.O. Box 889
Oklahoma City, OK 73101

Health Survey

Please complete this survey. The goal of this survey is to help us understand your health and specific health care needs so we can work together to help provide you the services to reach your health goal(s). Your answers **WILL NOT** affect your benefits. We may share your information with your primary care provider. If you have any questions regarding this please contact Customer Care - 1-844-280-5555 (TTY: 711) 8am - 8pm, 7 days a week (October 1 - March 31), 8am - 8pm, Monday - Friday (April 1 - September 30)

Date: _____ **Agent name and ID (if agent assisted):** _____

Name: _____ **Gender:** ☐ **Male** ☐ **Female**

DOB: _____ **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Phone number: _____

Application/MemberID: _____

1. **What is your race?**
☐ White ☐ Black or African American ☐ Native Hawaiian ☐ Samoan ☐ Other Pacific Islander
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japenese ☐ Korean ☐ Vietnamese ☐ Other Asian
☐ Guamanian or Chamorro ☐ I choose not to answer

2. **What is your Ethnicity?**
☐ Not Hispanic, Latino/a or Spanish Origin ☐ Cuban ☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican ☐ Another Hispanic, Latino/a or Spanish Origin ☐ I choose not to answer

3. **What is your primary language?**
☐ English ☐ Spanish ☐ Other: _____ ☐ I choose not to answer

4. **Please check whether you have ever had or have been treated for any of the following Chronic Conditions:**
☐ Alzheimer's Disease/Dementia ☐ Autoimmune Disease (Multiple Sclerosis/Myasthenia Gravis)
☐ Asthma ☐ Arthritis or Pain in Joints ☐ Cancer ☐ Congestive Heart Failure ☐ COVID-19 ☐ Diabetes
☐ Cardiovascular Disease/Cornary Artery Disease/Peripheral Vascular Disease ☐ Depression/Mental Illness
☐ Epilepsy/Seizures ☐ Heart Problems/Heart Disease/Heart Attack ☐ High Blood Pressure
☐ High Cholesterol/Triglycerides ☐ Kidney Disease/Failure ☐ Immune Disorder (HIV or AIDS)
☐ Lung Disease (Emphysema, Chronic Obstructive Pulmonary Disease-COPD)
☐ Neurodegenerative Disease (Parkinson's/Huntington's Disease) ☐ Organ Transplant (Liver, Kidney, etc.)
☐ Stroke

5. **Please check the following conditions you are currently experiencing or receiving medical treatment for:**
☐ Foot/Ankle/Leg Swelling ☐ Sudden Increase in Weight or Overweight ☐ Renal Dialysis
☐ Open Sores, Wounds or Ulcers on Your Skin

6. **Health Care Access and Treatment:**
a. Do you have transportation to and from your medical appointments? ☐ Yes ☐ No
b. Have you had a face-to-face (in-person or virtual) visit with your doctor for an Annual Physcial Exam or Wellness Visit in the past 12 months? ☐ Yes ☐ No
c. Are you currently or have you ever been enrolled in hospice? ☐ Yes ☐ No
d. How many times have you been to the emergency room in the past 12 months? ☐ None ☐ 1-3 times ☐ More than 3
e. How many times have you been admitted to the hospital in the past 12 months? ☐ None ☐ 1-3 times ☐ More than 3
f. When was your last complete dilated eye exam? ☐ Never ☐ Less than 12 months ago ☐ More than 12 months ago

7. **Activities of Daily Living:**

a. Do you need help with bathing or dressing yourself, preparing meals, feeding yourself, or using the bathroom? ☐ Yes ☐ No

b. Do you need help walking, getting up from a chair, or getting out of bed? ☐ Yes ☐ No

c. Do you need help taking your medications as prescribed? ☐ Yes ☐ No

e. Do you currently use assistive devices or durable equipment (wheelchair, walker, cane, raised toilet seat, etc.) to walk, bathe, shower, or use the bathroom? ☐ Yes ☐ No

f. In the past 12 months, how many times have you fallen whether in your home or at another location? ☐ Never ☐ Once ☐ More than once

8. **Behavioral and Social:**

a. In the past 12 months, have you felt sad, blue, or depressed? ☐ Yes ☐ No

b. In the past 12 months, have you experienced changes in thinking, remembering, or decision making? ☐ Yes ☐ No

c. Does forgetfulness (such as forgetting to pay bills or take your medications) cause problems in your daily life? ☐ Yes ☐ No

d. Do you smoke? ☐ Yes ☐ No

e. If you answered yes to Question D, would you like to receive information to help you quit smoking? ☐ Yes ☐ No

f. Do you drink alcohol often? ☐ Yes ☐ No

g. In the last 12 months, have you used illegal drugs or substances? ☐ Yes ☐ No

h. If you answered yes to Question G, would you like to receive information about controlling this problem? ☐ Yes ☐ No

i. Do you socialize with others regularly? ☐ Yes ☐ No

j. Do you exercise regularly or at least several days a week? ☐ Yes ☐ No

k. Do you currently feel threatened or that you are being physically, mentally, or sexually abused? ☐ Yes ☐ No

l. Do you experience feelings of stress in your life, like when handling things related to your health, finances, family or social relationships, work, etc.? ☐ Yes ☐ No

m. In general, how would you rate your overall health? ☐ Excellent/Very Good ☐ Good ☐ Fair ☐ Poor

n. In the past 3 months, have you had difficulty meeting your living expenses? ☐ Yes ☐ No

o. Would you like to receive information regarding advanced directives or living wills? ☐ Yes ☐ No

p. Do you have or need a caregiver to help you take care of your needs? ☐ Yes ☐ No

q. What is the highest level of education you completed?

☐ Grade School ☐ High School ☐ Vocational School ☐ College

r. How well can you read? ☐ Very Well ☐ Well ☐ Not Well ☐ I Cannot Read

9. **Medical Treatment/Vaccinations:**

a. How many different medications do you take every day? ☐ 1-3 ☐ 4-6 ☐ More than 6

b. When was your last flu shot? ☐ Never ☐ Within the last 12 months ☐ More than 12 months ago

c. When was your last pneumonia shot? ☐ Never ☐ Less than 10 years ago ☐ More than 10 years ago

d. Have you received the COVID-19 vaccination? ☐ Yes ☐ No

e. If you have received the COVID-19 vaccinations, have you received the full vaccination? ☐ Yes ☐ No