



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 - 1-844-200-8167 (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? <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> I choose not to answer	
2. What is your Ethnicity? <input type="checkbox"/> Not Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Another Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> I choose not to answer	
3. What is your primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ <input type="checkbox"/> I choose not to answer	
4. Please check whether you have ever had or have been treated for any of the following Chronic Conditions: <input type="checkbox"/> Alzheimer's Disease/Dementia <input type="checkbox"/> Autoimmune Disease (Multiple Sclerosis/Myasthenia Gravis) <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis or Pain in Joints <input type="checkbox"/> Cancer <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> COVID-19 <input type="checkbox"/> Diabetes <input type="checkbox"/> Cardiovascular Disease/Cornary Artery Disease/Peripheral Vascular Disease <input type="checkbox"/> Depression/Mental Illness <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Heart Problems/Heart Disease/Heart Attack <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol/Triglycerides <input type="checkbox"/> Kidney Disease/Failure <input type="checkbox"/> Immune Disorder (HIV or AIDS) <input type="checkbox"/> Lung Disease (Emphysema, Chronic Obstructive Pulmonary Disease-COPD) <input type="checkbox"/> Neurodegenerative Disease (Parkinson's/Huntington's Disease) <input type="checkbox"/> Organ Transplant (Liver, Kidney, etc.) <input type="checkbox"/> Stroke	
5. Please check the following conditions you are currently experiencing or receiving medical treatment for: <input type="checkbox"/> Foot/Ankle/Leg Swelling <input type="checkbox"/> Sudden Increase in Weight or Overweight <input type="checkbox"/> Renal Dialysis <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have you had a face-to-face (in-person or virtual) visit with your doctor for an Annual Physical Exam or Wellness Visit in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Are you currently or have you ever been enrolled in hospice?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. How many times have you been to the emergency room in the past 12 months?	<input type="checkbox"/> None <input type="checkbox"/> 1-3 times <input type="checkbox"/> More than 3
e. How many times have you been admitted to the hospital in the past 12 months?	<input type="checkbox"/> None <input type="checkbox"/> 1-3 times <input type="checkbox"/> More than 3
f. When was your last complete dilated eye exam?	<input type="checkbox"/> Never <input type="checkbox"/> Less than 12 months ago <input type="checkbox"/> 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