Fax completed form to 1-888-891-0019

Member Name: ______________________

Member ID: ______________________

Health Risk Assessment (HRA)

Member Demographic Information

Date of Birth: ________________ **Sex:** ☐ M ☐ F **Height?** Feet:______Inches:________ **Weight?** ________lbs

Address: ____ **Apt/Lot #:** ____________

City: ____________________________________ **State:** ________ **Zip:** ________________

Phone Number: ________________________ **Email:** ________________________________

Primary Language(s): ____

What is the highest grade or level of school or education you completed?

☐ 8th grade or less ☐ Some high school, but did not graduate ☐ High school or GED
☐ Some college ☐ 2 year college degree ☐ 4 year college degree ☐ Technical School/Training

What is your race/ethnicity? (select all that are applicable)

☐ African American or Black ☐ Pacific Islander ☐ Indian
☐ Asian ☐ Native Alaskan ☐ Other
☐ Caucasian or White ☐ Native American ☐ I prefer not to answer
☐ Hispanic ☐ Native Hawaiian

General Health Information (select one for each question)

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

Do you live alone? ☐ N ☐ Y **Are you homebound?** ☐ N ☐ Y **Do you have a caregiver?** ☐ N ☐ Y

In the past 3 months, how many times did you go to the Emergency Room (ER)?

☐ 0 ☐ 1 time ☐ 2 times ☐ 3 or more times

In the past 6 months, how many times have you had an overnight stay in a hospital (as a patient)**?**

☐ 0 ☐ 1 time ☐ 2 times ☐ 3 or more times

In general, how would you rate your dental health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you visit or communicate with your PCP regularly? ☐ N ☐ Y **If yes, how often?**________________

Do you have a living will or advanced directive? ☐ N ☐ Y ☐ Not Sure
If yes, does your PCP have a copy? ☐ N ☐ Y ☐ N/A

Do you have a Power of Attorney (POA) or healthcare surrogate? ☐ N ☐ Y ☐ Not Sure

Do you ever choose to not seek medical care because of religious or personal beliefs?

☐ N ☐ Y ☐ Prefer not to answer

Have you had any problems with balance or walking? ☐ N ☐ Y

Member Name: ____________________________

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Do you use or need any special DME equipment/supplies (walkers, trach supplies, ostomy, oxygen)**?** ☐ N ☐ Y

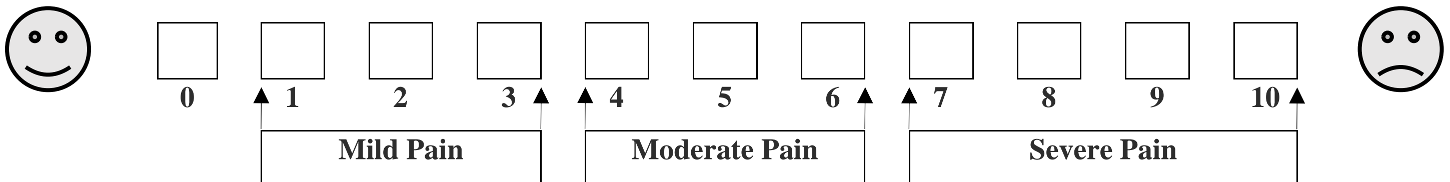
List the DME, if applicable: ____

In the past 6 months, have you fallen? ☐ N ☐ Y

If yes, does your PCP know about it? ☐ N ☐ Y ☐ N/A

Have you had problems with urine leakage? ☐ N ☐ Y

On a scale of 0-10, what is your normal pain level?
(0 = No Pain, 10 = Worse Pain Imaginable)



Location of Pain, if applicable: ____

Have you had any problems with your short-term memory? ☐ N ☐ Y
(e.g.: What did you have for dinner last night?)

Have you had any problems with your long-term memory? ☐ N ☐ Y
(e.g.: Where were you born?)

Rate how you feel about each of the following statements:	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
My health is important to me.				
I am ultimately the one responsible for taking care of my health and wellness.				
I am confident I can prevent or reduce problems associated with my health.				
I am confident I know when I need to seek medical care, and when I am able to take care of myself.				
I am confident I can talk to my doctor about my health concerns, even when he/she does not ask.				
I am confident I can follow through on medical treatments or care that I many need to do at home.				

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Medical History & Treatment Information (select all that apply)

What medical conditions do you have, or have had in the past?

☐ Anxiety
☐ Asthma
☐ Bi-polar Disorder
☐ Blood Disorder
☐ Cancer (Type:___________________)
☐ COPD/Emphysema
☐ Coronary Artery Disease
☐ Dementia/Alzheimer's
☐ Depression
☐ Diabetes (Type 1)
☐ Diabetes (Type 2)
☐ GERD/Stomach Issues
☐ Hearing Problems
☐ Heart Failure (CHF)
☐ Hypertension
☐ Organ Transplant
☐ Osteoarthritis (OA)
☐ Osteoporosis
☐ Peripheral Vascular Disease (PVD)
☐ Renal/Kidney Failure
☐ Rheumatoid Arthritis (RA)
☐ Seizures
☐ Schizophrenia
☐ Skin Issues/Wounds
☐ Stroke
☐ Vision Problems
☐ Other: __________________

Which of the following conditions are you currently receiving treatment for?

☐ Anxiety/Depression
☐ Arthritis
☐ Asthma
☐ Bi-polar/Schizophrenia
☐ Cancer (Type:___________________)
☐ COPD/Emphysema
☐ Coronary Artery Disease
☐ Dementia/Alzheimer's
☐ Diabetes
☐ Heart Failure (CHF)
☐ Hypertension
☐ Renal/Kidney Failure
☐ Stroke
☐ Other: __________________

Activities of Daily Living (Y=Yes, N=N0 and N/A=Not Applicable; please select one for each question below)

Do you need help with doing the following daily activities?

1) Standing up from a sitting position? ☐ N ☐ Y
2) Walking in the house? ☐ N ☐ Y
3) Walking outside of the house? ☐ N ☐ Y
4) Preparing a meal? ☐ N ☐ Y
5) Eating a meal? ☐ N ☐ Y
6) Using the toilet? ☐ N ☐ Y
7) Bathing? ☐ N ☐ Y
8) Getting dressed? ☐ N ☐ Y
9) Driving or getting to places? ☐ N ☐ Y

If you need help with any of the above activities, do you have someone who can help you?

☐ N ☐ Y ☐ N/A

Medication Information (select one for each question)

Do you take medications; and if so, how often do you take medications?

☐ No, never ☐ Yes, daily ☐ Yes, weekly ☐ Yes, as needed

How many medications do you take?

☐ 0 ☐ 1-3 ☐ 4-5 ☐ 6-7 ☐ 8+

Pharmacy Name: ____

Address: ______________________________________ **Phone:** _______________

Do you sometimes find you have to choose between buying groceries or medications? ☐ N ☐ Y ☐ N/A

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Preventive Services Information (select one for each service type by marking the boxes below)

When was the last time you had a:	2021	2020	2019	2018	2017	2016	Within the Last 10 Years	Never	N/A
Pneumonia Vaccine?									
Flu Vaccine?									
COVID-19 Vaccine?									
Breast Screening (Mammogram)?									
Colorectal Screening (Colonoscopy)?									
Cervical Screening (PAP Smear)?									
Bone Density Screening?									

Lifestyle (select one for each question)

How often do you exercise for at least 20 minutes in a day?

☐ Yes, daily ☐ Yes, 3 or more times a week ☐ Yes, less than 3 times a week ☐ No, never

In the past 2 weeks, have you had a change in your sleeping patterns, or are you having trouble obtaining restful sleep? ☐ N ☐ Y

Are you on a special diet recommended by your doctor (low sodium, low cholesterol, low fat)**?** ☐ N ☐ Y

If yes, what type of diet?: ____

How often do you eat fresh fruits or vegetables?

☐ Daily ☐ Often ☐ Yes, less than 3 times a week ☐ Never

How often do you eat fried or high-fat foods (fried fish or chicken, bacon, potato chips, doughnuts)**?**

☐ Daily ☐ Often ☐ Yes, less than 3 times a week ☐ Never

How often do you drink alcohol?

☐ Daily ☐ Often ☐ Yes, less than 3 times a week ☐ Never

Have you ever felt you should reduce your alcohol consumption? ☐ N ☐ Y ☐ N/A

When was the last time you smoked or used any tobacco product?
(cigarettes, chew, snuff, pipes, cigars, vapor cigarettes)

☐ Today ☐ Last week ☐ Last month ☐ 3 months ago
☐ Last year ☐ 1-5 years ago ☐ Longer than 5 years ago ☐ Never

Are you interested in quitting smoking? ☐ N ☐ Y ☐ N/A

In the past year, how many times have you used an illegal drug or a prescription medication for non-medical reasons? ☐ 0 ☐ 1 time ☐ 2 times ☐ 3 or more times

Do you have any hobbies or interests? ☐ N ☐ Y

If yes, please list: ____

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Emotional Health Information (select one for each question)

Over the past 2 weeks, how often have you felt nervous, anxious, or on edge?

☐ Not at all ☐ Several Days ☐ More days than not ☐ Nearly every day

Over the past 2 weeks, how often were you not able to stop worrying or control your worrying?

☐ Not at all ☐ Several Days ☐ More days than not ☐ Nearly every day

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

☐ Not at all ☐ Several Days ☐ More days than not ☐ Nearly every day

Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?

☐ Not at all ☐ Several Days ☐ More days than not ☐ Nearly every day

How often do you get the social and emotional support you need?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

How often do you get stressed handling your health, finances, relationships, or work?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Over the past 2 weeks, have you had thoughts of suicide? ☐ **N** ☐ **Y**

If yes, do you have a plan? ☐ N ☐ Y ☐ N/A

Form Completion Information (identify individual completing this HRA Form)

Who completed this HRA Form?: ☐ Member ☐ PCP ☐ Spouse ☐ Son/Daughter ☐ Caregiver ☐ Oher

Date HRA Form Completed: _______________________________

Print Full Name of Individual Filling Out this HRA Form: ____

If not filled out by Member, was the Member present while responding to and answering the HRA questions? ☐ *Y* ☐ *N*