Health Risk Assessment

Name		SHP ID Number	
Phone Number(s)		Date	

Dear Member:

This assessment is designed to provide Sonder Health Plans with some important health information. The information that we request will help us understand and assist you with your individual healthcare needs. The information you provide is part of your personal health information. This information is held in strict confidence and privacy and will NOT be shared or released to anyone other than your treating physician(s) without your written consent.

Medical Conditions and Biometric Measures

1. In general, would you say your health is:
   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

2. Have you ever been told that you had, or have you ever been treated for the following conditions?

Alzheimer's Disease/Parkinson's Dementia/ Memory loss	□ YES □ NO	Kidney Disease or Failure	□ YES □ NO
Amputation	□ YES □ NO	Depression/Mental Illness	□ YES □ NO
Asthma	□ YES □ NO	Immune Disorder (HIV or AIDS)	□ YES □ NO
High Cholesterol/Triglycerides	□ YES □ NO	Lung Disease (Emphysema, COPD)	□ YES □ NO
Arthritis or pain in joints	□ YES □ NO	Diabetes	□ YES □ NO

Cancer	□ YES □ NO	High Blood Pressure	□ YES □ NO
Nerve disorder such as Multiple Sclerosis or ALS	□ YES □ NO	Stroke	□ YES □ NO
Epilepsy/Seizures	□ YES □ NO	Paralysis	□ YES □ NO
Heart / Coronary artery disease	□ YES □ NO	Organ Transplant (liver, kidney, etc.	□ YES □ NO
Congestive Heart Failure	□ YES □ NO		

3. Which of these conditions are you currently experiencing and/or receiving treatment for?

Leaking of urine?	□ YES □ NO
Leaking of stool?	□ YES □ NO
Foot/Ankle/Leg Swelling?	□ YES □ NO
Pregnant?	□ YES □ NO
Renal Dialysis?	□ YES □ NO
Open sores, wounds, or ulcers on your skin?	□ YES □ NO
Weight problems?	□ YES □ NO
Height	In.
Weight	lbs.

4. If your blood pressure was checked within the past year, what was the resultwhen last checked?
   - □ At or below 120/80
   - □ Between 121/81-139/89
   - □ Between 140/90 or higher
   - □ Don't know

5. If your cholesterol levels were checked within the past year, what was the result?
   - □ At or below of 200 mg/dl
   - □ Higher than 200mg/dl
   - □ Don't know

6. If your fasting blood glucose was checked within the past year, what was the result?
   - □ Below 100mg/dl

- ☐ Between 100-125mg/dl
- ☐ At or higher 126mg/dl
- ☐ Don't know

7. Was your last hemoglobin A1C under 7.0 %?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

8. How is your vision? (Inclusive of while using eyeglasses or contact lens)
   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

9. How is your hearing? (Inclusive of while using hearing aid, if used)
   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

10. Have you seen a dentist in the past 12 months?
    - □ Yes
    - □ No

11. Do you have any tooth pain or bleeding from your gums?
    - □ Yes
    - □ No

12. How many different prescription medications do you take every day?
    - ☐ None
    - ☐ 1 to 5 medications
    - ☐ 6 or more medications

13. In the previous 12 months, how many times have you fallen?
    - ☐ Never
    - ☐ Once

- ☐ More than once

14. If you are currently bothered with pain, please tell us how bad the pain is, with 1 being very little pain, 5 being moderate pain, and 10 being severe pain:
    - ☐ I have no pain
    - ☐ 1 to 3
    - ☐ 4 to 6
    - ☐ 7 to 10

15. During the PAST 4 WEEKS, how much did pain interfere with your normal work(including both outside the home and housework)?
    - ☐ Never
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

Healthcare access and treatment

16. Are you currently or have you ever been enrolled in Hospice?
    - ☐ Yes
    - ☐ No

17. How many times have you been to the Emergency Room within the past year (12 months)?
    - □ None
    - □ 1 to 3
    - □ More than 3

18. How many times have you been admitted to the hospital within the past year (12 months)?
    - □ None
    - □ 1 to 3
    - □ More than 3

Nutrition

19. How many portions of fruits and vegetables do you eat daily?
    - ☐ Less than four portions of fruits and vegetables per day
    - ☐ Four or more portions of fruits and vegetables per day

20. Do you eat two or more of the following: donuts, cakes, cookies, desserts,carbonated and fruit drinks in one day?
    - ☐ Yes
    - ☐ No

Lifestyle

21. In the last 30 days, have you used tobacco?
    - ☐ No
    - ☐ Yes
        - ☐ If yes, would you like to receive information to assist you to stop smoking? □ YES □ NO

22. How often do you have a drink containing alcohol?
    - ☐ Never
    - ☐ 1 per month or less
    - ☐ 2-4 times per month
    - ☐ 2-3 times per week
    - ☐ 4 or more times per week

23. How many drinks containing alcohol do you have on a typical day when you aredrinking?
    - ☐ 1-2 drinks
    - ☐ 2-4 drinks
    - ☐ 4 or more
    - ☐ Not applicable

24. Do you use illegal drugs/substances?
    - ☐ No
    - ☐ Yes
        - ☐ If yes, would you like to receive information to assist you to stop using? □ YES □ NO

25. Do you take precautions to avoid health risk such as: using a seat belt when riding in a car and avoid walking on slippery surfaces?
    - ☐ Yes

- ☐ No

Physical Activity

26. In the past week how many days did you exercise for at least 30 minutes?
    - ☐ none
    - ☐ 1-2 days
    - ☐ 3-5 days
    - ☐ 6-7 days

27. How intense is your typical exercise?
    - ☐ Light (such as stretching or slow walking)
    - ☐ Moderate exercise (such as brisk walking)
    - ☐ Heavy (such as jogging or swimming)
    - ☐ I am currently not exercising

Functional Screening

28. Bathing
    - ☐ I can do it without help
    - ☐ I need help
    - ☐ I can't do it without help

29. Dressing
    - ☐ I can do it without help
    - ☐ I need help
    - ☐ I can't do it without help

30. Use the bathroom
    - ☐ I can do it without help
    - ☐ I need help
    - ☐ I can't do it without help

31. Walking
    - ☐ I can do it without help
    - ☐ I need help
    - ☐ I can't do it without help

32. Taking medications
    - ☐ I can do it without help
    - ☐ I need help

- ☐ I can't do it without help

33. Grocery Shopping/ Meal preparation
    - ☐ I can do it without help
    - ☐ I need help
    - ☐ I can't do it without help

34. Housekeeping
    - ☐ I can do it without help
    - ☐ I need help
    - ☐ I can't do it without help

35. Managing your finances
    - ☐ I can do it without help
    - ☐ I need help
    - ☐ I can't do it without help

36. Telephone use
    - ☐ I can do it without help
    - ☐ I need help
    - ☐ I can't do it without help

Social Barriers

37. Is there a friend, relative or neighbor who could take care of you for a few days, if necessary?
    - ☐ Yes
    - ☐ No

38. Do you have transportation to get to your doctor and medical appointments?
    - ☐ Yes
    - ☐ No

39. Are you able to read?
    - ☐ Yes
    - ☐ No

40. Are you able to write?
    - ☐ Yes
    - ☐ No

41. If you are employed, how many times have you missed work due to personal orfamily health issues?
    - ☐ 1-2 times a month
    - ☐ 3-4 times a month
    - ☐ More than 4 times a month
    - ☐ Not applicable

Cognitive Status

42. Have any friends or family members expressed concerns about your memory?
    - ☐ Yes
    - ☐ No

43. Do you remember what you had for breakfast this morning"?
    - ☐ Yes
    - ☐ No

44. Do you know the name of the President of the U.S."?
    - ☐ Yes
    - ☐ No

Stress

45. Do you currently (now) feel threatened or that you are being physically, mentally, or sexually abused?
    - ☐ Yes
    - ☐ No

46. How often is stress a problem for you in handling things such as: your health,your finances, your family or social relationships, your work?
    - ☐ Never
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

Anxiety

47. In the past 2 weeks, how often have you felt nervous, worried, anxious

or on edge?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Always

48. When you felt worried, nervous, or anxious did you act differently?
    - ☐ Yes
    - ☐ No
    - ☐ Not applicable

Sleep

49. Are you having sleeping problems such as difficulty falling asleep or staying asleep or feeling sleepy during the day?
    - ☐ Yes
    - ☐ No

Mental Health

50. Over the past two weeks, how often have you felt little pleasure or no interest indoing things?
    - ☐ Not at all
    - ☐ Several days
    - ☐ More than 7 days
    - ☐ Everyday

51. In the past two weeks, how often have you felt down, depressed, or hopeless?
    - ☐ Not at all
    - ☐ Several days
    - ☐ More than 7 days
    - ☐ Everyday

Socioeconomic Data

52. What is your primary race and/or ethnicity?

- ☐ African American/Black
- ☐ White
- ☐ Asian/Pacific Islander
- ☐ Native American/ Alaskan Native
- ☐ Hispanic
- ☐ Prefer not to answer
- ☐ Other

53. What is your highest level of education?
    - ☐ Did not graduate from high school
    - ☐ High school graduate
    - ☐ College
    - ☐ Graduate school

54. What is your annual Household Income?
    - ☐ Less than $10,000
    - ☐ $10,000-$19,999
    - ☐ $20,000-$29,999
    - ☐ $30,000-$49,999
    - ☐ $50,000 or More
    - ☐ Don't know

55. Do you live in:
    - ☐ An independent house, apartment, condominium o mobile home?
    - ☐ In a senior housing or assisted-living apartment?
    - ☐ Nursing home
    - ☐ Other, explain _____

56. Who do you live with?
    - ☐ Alone
    - ☐ Homeless
    - ☐ Institution Long-term care
    - ☐ Live with Child
    - ☐ Live with Family/Parent
    - ☐ Live with Friends
    - ☐ Spouse
    - ☐ Caregiver
    - ☐ Other: _____
57. Do you have a living will or Durable Power of Attorney for healthcare?
    - ☐ Yes
    - ☐ No

- ☐ If “NO”, would you like to receive more information regarding advanced directives and living wills?
  - ☐ Yes
  - ☐ No

Preventive Care

58. Within the past 12 months have you had any of the following (check all that apply)?
    - ☐ Annual physical exam or wellness visit
    - ☐ Colorectal cancer screening
    - ☐ Cervical cancer screening
    - ☐ Breast cancer screening
    - ☐ Influenza vaccination
    - ☐ Pneumonia shot
    - ☐ Complete eye exam with having eyes dilated
    - ☐ None

DME

59. Do you currently use any of the following special DME equipment / supplies (check all that apply)?
    - ☐ CPAP machine
    - ☐ Oxygen
    - ☐ Electric bed
    - ☐ Wheelchair or motorized mobility device
    - ☐ Other:_____

Please sign, print, and date on the line below. If someone other than the member is completing the form, please indicate the relationship to the member (e.g., Self, Spouse, etc.).

Return this form to us in the self-addressed, stamped envelope, or call Sonder Health Plans Member Services Department toll free at 1-888-428-4440 / (TTY/TDD 711) if you need help completing this form.

Signature: _____**Print Name:** _____

Relation:_____ **Date**: ___/___/_____

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<MLI LANGUAGE>
<HEALTH PLAN DISCLAIMER>

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