HEALTH RISK ASSESSMENT

Each year, we ask our members to complete and return this health assessment as soon as possible. Our Care Support team will use the information to learn more about you and support your health care needs. The information you provide will be treated confidentially. Completion and submission of this form implies that you agree to have this information used for this purpose.

Experience Health

Complete and mail to:

PO Box 52382
Durham, NC 27717-9942

First name: _____ **Last name:** _____

Date of birth: _____ **Member number:** _____

Home phone: _____ **Mobile phone:** _____

Email: _____

Primary Care Provider: _____

1. In general, how would you rate your overall health?

____ Excellent ____ Good ____ Fair ____ Poor

2. Compared to a year ago, is your health:

____ Better ____ About the same ____ Somewhat worse ____ Much worse

3. What health conditions do you currently have?
(Please mark each condition that applies to you)

____ N/A – no health conditions
____ Heart disease
____ Depression
____ High blood pressure
____ Asthma
____ Heart failure or an enlarged heart
____ COPD or other obstructive lung disease
____ Diabetes
____ Kidney disease
____ Other conditions (Please list on line below)

_____

_____

4. How many different medicines do you take? ***(Put the number of each type in the blank)***

____ Prescription medications ____ Over-the-counter medications

____ Non-prescription medications (vitamins, herbs, supplements) ____ N/A – None

How often do you miss taking your medication(s)?

____ All of the time ____ Most of the time ____ Less than half the time ____ None of the time

5. Have you had an annual physical by your Primary Care Provider in the last year?

____ Yes ____ No

6. Do you ever skip getting the health care or taking the medication you need because of: ***(Please check all that apply)***

____ Couldn't afford it or not sure I can afford it

____ Difficulty getting an appointment

____ Access to transportation

____ Your role as a caregiver (children, spouse, parents, etc.)

____ Stress, fear and/or worry

____ N/A – I don't skip getting health care or taking my medication

7. Over the last two weeks, how often have you been bothered by any of the following problems?

A. Little interest or pleasure in doing things

____ Not at all ____ Several days ____ More than half the days ___ Nearly every day

B. Feeling down, depressed or hopeless

____ Not at all ____ Several days ____ More than half the days ___ Nearly every day

8. Do you use the following?

	No	Yes	If yes, average # times per day
Tobacco			
Vape / E-Cigarettes			
Cigar			
Pipe Tobacco			
Smokeless			

9. Have you fallen or almost fallen in the past 3 months? ____Yes ____ No

Do you have trouble balancing or worry about falling? ____Yes ____ No

10. Are you physically active? ***(e.g., walking, group classes, stationary bike, etc.)***

____Yes ____ No

What is your average level of physical activity during the week?

____ None

____ Light (e.g., walk around my home)

____ Moderate (e.g., climb a flight of stairs, walk around grocery store/town)

____ Heavy (e.g., walk multiple times a day, run, swim, work out at gym)

11. Do you use any of the following to get around? ***(Select all that apply)***

___ Cane ___ Walker ___ Wheelchair

___ Prosthetic device ___ Power operated vehicle (scooter) ___ None

12. Do you require assistance with any of the following activities?

___ Bathing ___ Eating meals ___ Dressing

___ Housekeeping ___Toileting ___Transportation

___Walking ___ Shopping and errands ___Taking medications

___ Preparing meals ___ None

Who provides assistance with the above activities? ***(Please check all that apply)***

____ Family member ____ Hired aide ____ Friend

____ Other (specify) _____

13. In the last year, how many times have you gone to the emergency room? _____

14. In the last year, how many unplanned stays have you had in the hospital? _____

15. My personal health goals *(please choose up to three)* are:

- ☐ Have my own **health care provider**
- ☐ Improve my **cholesterol**
- ☐ Get the right amount of **exercise**
- ☐ Reach a **healthy weight**
- ☐ **Reduce stress** in my life
- ☐ **Learn more** about my health
- ☐ **Feel better** and have **more energy**
- ☐ Find out what **preventive services** I need
- ☐ Control my **blood pressure**
- ☐ Get my **blood sugar** under control
- ☐ Eat a **healthy diet**
- ☐ Stop my **tobacco use**
- ☐ Reach a **better balance** in my life
- ☐ Stay in **good health**
- ☐ Address my **alcohol or substance use**

16. Have you had a vision exam in the last year? ____Yes ____ No

Do you wear glasses or contacts? ____Yes ____ No

17. Have you had a preventive dental visit or cleaning in the last year? ____Yes ____ No

18. Have you had a hearing exam in the last year? ____Yes ____ No

Do you use a hearing aid? ____Yes ____ No

19. Is there anything else you want to share about your health?

_____

_____

_____

_____

_____

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