Health Risk Assessment Form

PASSPORT HEALTH PLAN

Now that you are a member of Passport Health Plan, we ask that you please fill out this form. It will help us see how we can best serve you with our benefits and special programs. Your answers on this form will be kept private. They will not affect your benefits in any way. If you need help filling out this form, please call 1-877-903-0082. TDD/TTY users may call 1-800-691-5566.

Date _____

Name (first) _____ **(middle initial)** _____ **(last)** _____

Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Daytime Phone _____ **Date of birth** _____

Last four digits of your Social Security #: _____

Passport Health Plan ID number: _____

What is the name of your primary care provider (PCP)? _____

What is your PCP's phone number? _____

Do you need help choosing a PCP or making an appointment with your PCP? ❑ Yes ❑ No

What is your preferred language?

❑ English ❑ Somali ❑ Spanish ❑ Arabic ❑ Vietnamese ❑ Bosnian
❑ Russian ❑ Swahili ❑ French ❑ Mandarin ❑ Sign ❑ Other _____

What is your gender? ❑ Male ❑ Female

What is your race? (optional)

❑ American Indian/ Alaskian Native ❑ Asian ❑ Black or African American ❑ White
❑ Native Hawaiian/ Pacific Islander ❑ Declined to Answer ❑ Other_____

What is your ethnicity? (optional)

❑ Hispanic ❑ Non-Hispanic ❑ Other_____ ❑ Declined to Answer

Are you pregnant? ❑ Yes ❑ No

If yes, what is the name of your OB provider (doctor who cares for you during pregnancy)? _____

What is your OB's phone number? _____

If you are pregnant and do not have an OB provider, do you need help choosing one? ❑ Yes ❑ No

When was your last physical exam? _____

What is your current height? _____ **What is your current weight?** _____

Section One: Physical and Behavioral Health

1 2 3 4 5	1. In general, would you say your health is: (circle one number) 1 - Excellent 2 - Very Good 3 - Good 4 - Fair 5 - Poor
	The following are activities you might do during a normal day. Please circle one of the numbers to describe how much your health limits you in any of these activities. 1 - Yes, limited a lot 2 - Yes, limited a little 3 - No, not limited (circle one number on each line)
1 2 3	2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.
1 2 3	3. Climbing several flights of stairs.
	During the past 4 weeks, have you had any of the following problems with your work or daily activities as a result of your physical health?
☐ Yes ☐ No	4. Could not get done as much as I would like.
☐ Yes ☐ No	5. Was limited in the kind of work or other activities.
	During the past 4 weeks, have you had any of the following problems with your work or daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
☐ Yes ☐ No	6. Could not get done as much as I would like.
☐ Yes ☐ No	7. Did not do work or other activities as carefully as usual.
1 2 3 4 5	8. During the past 4 weeks, how much did pain get in the way of your normal work (including both work outside the home and housework)? 1 - Not at all 2 - Slightly 3 - Moderately 4 - Quite a bit 5 - Extremely (circle one number)
	These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. 1 - All of the time 2 - Most of the time 3 - A good bit of the time 4 - Some 5 - A little of the time 6 - None of the time During the past 4 weeks, how often: (circle one number on each line)
1 2 3 4 5 6	9. Have you felt calm and peaceful?
1 2 3 4 5 6	10. Did you have a lot of energy?
1 2 3 4 5 6	11. Have you felt sad or down?
1 2 3 4 5 6	12. During the past 4 weeks, how often has your physical health or emotional problems gotten in the way of your social activities (such as visiting with friends, relatives, etc.)?
☐ Yes ☐ No	13. Have you seen a psychiatrist or any other mental/emotional health provider previously?
☐ Yes ☐ No	14. Have you ever been in a psychiatric facility?
☐ Yes ☐ No	15. Are you on any behavioral health medicines? If yes, what are they? _____
☐ Yes ☐ No	16. Have you ever been treated for substance abuse (alcohol, drugs)?
☐ Yes ☐ No	17. Do you need help getting a counselor, therapist, or psychiatrist?
☐ Yes ☐ No	18. Do you need help getting food, clothing or housing?

	19. Has the doctor EVER told you that you had any of the following conditions? (check YES or NO for each line)
☐ Yes ☐ No	a. Congestive heart failure
☐ Yes ☐ No	b. Chronic lung disease (including bronchitis, emphysema or COPD)
☐ Yes ☐ No	c. Diabetes Mellitus (sugar diabetes)
☐ Yes ☐ No	d. Asthma
☐ Yes ☐ No	e. Sickle Cell
☐ Yes ☐ No	f. HIV/AIDS
☐ Yes ☐ No	g. Hypertension (high blood pressure)
☐ Yes ☐ No	h. Heart attack
☐ Yes ☐ No	i. Stroke
☐ Yes ☐ No	j. End stage kidney disease requiring dialysis
☐ Yes ☐ No	k. Cancer
☐ Yes ☐ No	l. Autoimmune disorders (rheumatoid arthritis, lupus, multiple sclerosis)
☐ Yes ☐ No	m. Dementia
☐ Yes ☐ No	n. End stage liver disease
☐ Yes ☐ No	o. Blood disorders, clotting disorders
☐ Yes ☐ No	p. Neurologic disorders
☐ Yes ☐ No	q. Cardiovascular disorders
☐ Yes ☐ No	r. Chronic mental health conditions
☐ Yes ☐ No	s. Smoker's cough
☐ Yes ☐ No	t. Chronic kidney disease
☐ Yes ☐ No	20. Compared to one year ago, my health in general is much worse.

Section Two: Preventive Health

1 2 3	1. How would you describe your smoking habits? 1 - Still smoke 2 - Used to smoke 3 - Never smoked
1 2 3 4	2. How long has it been since your last tetanus shot? 1 – Within the last year 2 – Within the last 10 years 3 – More than 10 years ago 4 – Do not know
1 2 3 4	3. How long has it been since your last flu shot? 1 – Within the last 6 months 2 – Within the last year 3 – Do not know 4 – Never

1 2 3 4 5	**(If your age is 50 or over)** 4. How long has it been since your last colorectal exam (including colonoscopy, stool blood test)? 1 – less than 1 year ago 2 – 1 year ago 3 – 2 years ago 4 – 3 or more years ago 5 – Never
1 2 3 4 5	**(If your age is 18 or over)** 5. How long has it been since your last dilated retinal exam (eye exam by an eye specialist)? 1 – less than 1 year ago 2 – 1 year ago 3 – 2 years ago 4 – 3 or more years ago 5 – Never
Women Only	
1 2 3 4 5 6	**(If your age is 40 or over)** 6. How long has it been since your last mammogram (a test for breast cancer)? 1 – Less than 1 year ago 2 – 1 year ago 3 – 2 years ago 4 – 3 or more years ago 5 – Never 6 – I have had both breasts removed
1 2 3 4 5 6	**(If your age is 21 and over)** 7. How long has it been since you had a Pap smear (test for cervical cancer)? 1 – less than 1 year ago 2 – 1 year ago 3 – 2 years ago 4 – 3 or more years ago 5 – Never 6 – I have had a hysterectomy
Men Only	
1 2 3 4 5	8. How long has it been since you had a rectal or prostate exam? 1 – less than 1 year ago 2 – 1 year ago 3 – 2 years ago 4 – 3 or more years ago 5 – Never

Thank you for filling out the Health Risk Assessment!

Please mail this back in the white postage-paid envelope we sent you, or to the following address:

Passport Health Plan
Attn: Health Risk Assessment
5100 Commerce Crossings Drive
Louisville, KY 40229