MEDICARE MEMBER ANNUAL HEALTH ASSESSMENT FORM

First, Last Name: ______________________ **Member ID#:** ______________________

DOB: ____________

What is the language you prefer to use? ❑ English ❑ Spanish ❑ Chinese ❑ Creole ❑ Urdu ❑ Bengali

❑ Other (please indicate language): ______________________

In general, would you say that your health is: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you have a doctor you see regularly? ❑ Yes ❑ No

Do you have any of the following? ❑ Diabetes ❑ Heart problems ❑ Heart failure ❑ High blood pressure ❑ Breathing problems (asthma or COPD) ❑ Cancer ❑ Pain that won't go away ❑ Weight problem ❑ Memory problem ❑ Hearing problems ❑ Vision problems ❑ Mental problems ❑ Drug or alcohol problems ❑ Other medical problems: ______________________

Do you smoke cigarettes or use tobacco? ❑ Yes ❑ No

Do you need help with your basic activities (such as getting dressed, taking a bath, eating, getting in / out of a chair)?

❑ Able to do this without help ❑ Need help and get the help I need ❑ Need help and do not get the help I need

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Do you need help with housekeeping, taking medication, shopping, money management, or transportation?

❑ Able to do this without help ❑ Need help and get the help I need ❑ Need help and do not get the help I need

Did you fall in the past 6 months? ❑ Yes ❑ No

Do you use any of the following: ❑ Cane ❑ Walker ❑ Wheelchair ❑ Hospital Bed ❑ Oxygen ❑ None

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Do you currently receive public assistance (Food Stamps, Meals on Wheels, ADAP, EPIC, etc.)?

❑ Yes ❑ No ❑ Do not know

How many different medicines do you take a day? ❑ None ❑ 1-3 ❑ 4-7 ❑ 8 or more

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

❑ Not at all ❑ Several Days ❑ More than ½ the days ❑ Nearly every day

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

❑ Not at all ❑ Several Days ❑ More than ½ the days ❑ Nearly every day

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Did you have the seasonal Influenza Vaccine (Flu Shot) this year? ❑ Yes ❑ No ❑ Allergic ❑ Do not know

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ONLY WOMEN 50-74 YEARS OLD: Did you have a mammogram (to check for breast cancer) this year or last?

❑ Yes ❑ No ❑ Do not know

ONLY THOSE 50-75 YEARS OLD: Did you have the following tests to check for colon cancer?

❑ Colonoscopy (in the past 10 yrs.) ❑ Sigmoidoscopy (in the past 5 yrs.) ❑ Stool Test for blood (within the last yr.)

Do you have any of the following?

❑ Advance directive/Living will (document with your wishes for medical treatment if you aren't able to express your choice)

❑ Health care proxy (a person who would make healthcare decisions for you, if you are not able to)

❑ No, but advanced care planning was discussed with me

❑ No, and advanced care planning was not discussed with me