METROPLUSHEALTH MEMBER ANNUAL HEALTH ASSESSMENT FORM | TELL US HOW YOU'RE DOING.

PLEASE COMPLETE IN FULL AND MAIL BACK TO US AT:

MetroPlusHealth • 50 Water Street, 7th Fl. • New York, NY 10004

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

Mailing Address: _____

Phone: _____ Date of Birth: _____ Height: _____ft. _____ in. Weight: _____lbs.

Preferred Language: ❑ English ❑ Spanish ❑ Chinese ❑ Creole ❑ Urdu ❑ Bengali ❑ Other: _____

Would you like us to call you to help you with any health problems? ❑ Yes ❑ No

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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 ❑ High blood pressure ❑ Cancer

❑ Breathing problems (asthma or COPD) ❑ Memory problems ❑ Hearing problems ❑ Vision problems

❑ Mental problems ❑ Drug or alcohol problems ❑ Other medical problems: _____

_____

Do you have repeated or ongoing pain?

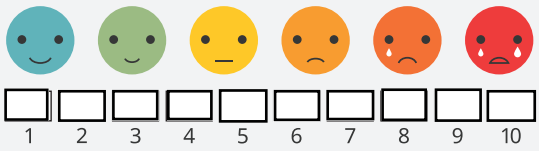
❑ Yes ❑ No **If yes,** start date: _____

If yes, where is the pain? _____

_____

_____

If yes, mark off your level of pain here:



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

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

❑ I'm able to do this without help ❑ I need help, and get the help I need ❑ I need help, and do not get the help I need

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

❑ I'm able to do this without help ❑ I need help, and get the help I need ❑ I need help, and do not get the help I need

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

Does anyone in your life hurt you, threaten you, frighten you, or make you feel unsafe?

❑ Yes ❑ No ❑ Prefer not to answer

Do you use any of the following:

❑ Cane ❑ Walker ❑ Wheelchair ❑ Hospital bed ❑ Oxygen ❑Adult diapers

❑ Other _____

What is your living situation?

❑ I have a steady place to live ❑ I have a place to live today, but I am worried about losing it in the future

❑ I do not have a steady place to live (temporarily staying with others, in a hotel, shelter, living outside on street, on a beach, in a car, abandoned building, bus or train station, park, other)

Are you worried that the place you are living now is making you sick? (i.e. mold, bugs/rodents, water leaks, not enough heat, other) ❑ Yes ❑ No ❑ Other: _____

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

❑ Yes ❑ No ❑ I do not know

In the past year, did you worry that your food could run out before you got money to buy more?

❑ Yes ❑ No ❑ Prefer not to answer

In the past year, has the electric, gas, oil, or water company threatened to shut off services to your home?

❑ Yes ❑ No ❑ I do not know

Do you smoke cigarettes, vape (e-cigarettes), or use tobacco? ❑ Current ❑ Former ❑ Never

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Did you have the Influenza Vaccine (Flu Shot) this year? ❑ Yes ❑ No ❑ I'm allergic ❑ I do not know

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Please list your medications (list additional medications of an extra sheet, if applicable):

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication List (continued - list additional medications of an extra sheet, if applicable):

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

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

❑ Not at all ❑ Several Days

❑ More than half of those days ❑ Almost every day

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

❑ Not at all ❑ Several Days

❑ More than half of those days ❑ Almost every day

ONLY WOMEN 50 YEARS OLD AND UNDER: Are you pregnant? ❑ Yes ❑ No ❑ I do not know

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

❑ Yes ❑ No ❑ I 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 (a document that says what medical treatment you would like if you are unable to speak for yourself)**

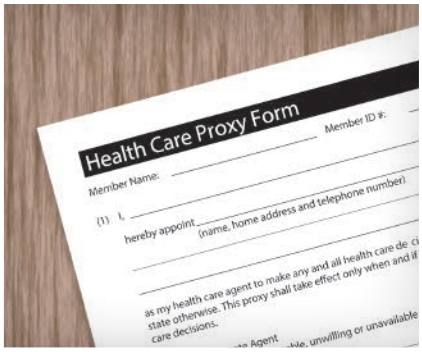
❑ **Health Care Proxy (a person who can make health care decisions for you, if you are not able to)**

❑ **No, but advanced care planning was discussed with me**

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

❑ **No, but I am interested to learn more:** ❑ Yes* ❑ No

* We will send you an Advance Directive and Health Care Proxy Form



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Date Completed: _____

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