

Health Risk Assessment

Instructions: Please print clearly, and fill out each appropriate box with an X as shown, using an ink pen or a dark lead pencil. If you need assistance you may have someone fill out this form for you.

Name: _____

Date of Birth: _____ Today's Date: _____

Address: _____

Phone Number: _____

BCN Advantage ID Card Number: _____

Medicare ID Card Number (HIC Number): _____

- 1 In general, would you say your health is: (Check one answer.)
1 Excellent 2 Very Good 3 Good 4 Fair 5 Poor
- 2 In the previous 12 months, have you stayed overnight as a patient in a hospital?
1 Not at all 2 One time 3 Two or three times 4 More than three times
- 3 In the previous 12 months, how many times did you visit a physician or clinic?
1 Not at all 2 One time 3 Two or three times 4 Four to six times 5 More than six times
- 4 In the previous 12 months, did you have diabetes?
1 Yes 2 No
- 5 Have you ever had:
A. Coronary heart disease? 1 Yes 2 No 3 Don't know
B. Angina pectoris? 1 Yes 2 No 3 Don't know
C. A myocardial infarction? 1 Yes 2 No 3 Don't know
D. Any other heart attack? 1 Yes 2 No 3 Don't know
- 6 Is there a friend, relative, or neighbor who would take care of you for a few days, if necessary?
1 Yes 2 No
- 7 Please check all those conditions for which you are currently receiving medical treatment.
 Breathing problems Arthritis
 High blood pressure Mental problems
 Heart problems Ankle/leg swelling
 Urinary problems Cancer

Health Risk Assessment (page 2)

8 Do any of your health conditions interfere with your daily activities?

1 Yes 2 No

9 Have you ever had:

A. Osteoporosis? 1 Yes 2 No 3 Don't know

B. Stroke? 1 Yes 2 No 3 Don't know

C. COPD?
(Chronic obstructive pulmonary disease) 1 Yes 2 No 3 Don't know

D. Kidney Disease? 1 Yes 2 No 3 Don't know
If yes, are you currently on dialysis? 1 Yes 2 No

E. Heart failure or
Congestive Heart Failure (CHF)? 1 Yes 2 No 3 Don't know

10 Are you currently receiving Medical Assistance or Medicaid?

1 Yes 2 No 3 Don't know

11 Do you live: (Check one answer.)

1 Alone 4 With other family, who? _____

2 With spouse 5 Other, explain. _____

3 With a son or daughter

12 Do you live in: (Check one answer.)

1 An independent house, apartment, condominium or mobile home?

2 An assisted-living apartment or board and care home?

3 A nursing home

4 Other, explain _____

13 If you live in other than your private home, what is the name of the facility you live in?

14 Please provide the facility's phone number: () -
Area code Telephone Number

Health Risk Assessment (page 3)

15 Please circle 1, 2, or 3 for each of these:

	Able to do this without help	Need some help	<u>Cannot</u> do this at all without help
Bathing	1	2	3
Dressing	1	2	3
Eating	1	2	3
Toileting	1	2	3
Walking	1	2	3
Taking medications	1	2	3
Meal preparation	1	2	3
Housekeeping chores	1	2	3
Shopping and errands	1	2	3
Transportation	1	2	3
Money management	1	2	3
Getting in/out of chairs/bed	1	2	3

16 A fall is when your body goes to the ground without being pushed. Did you fall in the past 12 months?
1 Yes 2 No

17 How many different prescription medications do you take?
Number of medicines:

18 How many over-the-counter medications do you take every day (for example, aspirin, vitamins, etc.)?
Number of over-the-counter medicines:

19 Do you now smoke every day, some days, or not at all?
1 Every day 2 Some days 3 Not at all 4 Don't know

20 How is your eyesight? (This means eyesight while wearing glasses or contacts, if you use them.)
1 Excellent 2 Good 3 Fair 4 Poor 5 None

21 How often do you exercise per week?
1 5 or more times a week 2 3 or 4 times a week 3 1 or 2 times a week 4 Not at all

Health Risk Assessment (page 4)

22 In the past six months, have you lost more than 10 pounds without trying?
1 Yes 2 No 3 Don't know

23 How much do you weigh? pounds

24 How tall are you? feet inches

25 Do you often feel sad or blue?
1 Yes 2 No

26 Are you?
1 Male 2 Female

27 Did you receive help filling out this form?
1 Yes 2 No

**Thank you for taking the time to complete this questionnaire.
Please return it in the supplied postage paid envelope.**

Return Address:

**BCN Advantage
Blue Care Network
P.O. Box 5184
Southfield, MI 48086-5184**



Medicare and more

Blue Care Network of Michigan is an equal opportunity and independent licensee of the Blue Cross and Blue Shield Association.