HEALTH RISK ASSESSMENT

Steward Health Care Network
HEALTH CHOICE GENERATIONS

The following questions are part of your health risk assessment, which is an evaluation of your overall health. This information will be used by Steward Health Choice Generations (HMO SNP) to create your individualized care plan (your health goals for the year), which will be sent to you.

IMPORTANT: Be sure to complete your Name and Member ID. This information will help us know who you are.

Full Name: _____ Date of Birth: _____

Member ID Number: _____ Phone: _____

Address: _____

Primary Care Physician: _____ Current Date: _____

Physical Activity	
In the past 7 days, how many days did you exercise?	_____ Days
On days when you exercised, for how long did you exercise (in minutes)?	_____ Minutes/Day ☐ N/A
How intense was your typical exercise?	☐ Light (like stretching or slow walking) ☐ Moderate (like brisk walking) ☐ Heavy (like jogging or swimming) ☐ Very heavy (like fast running or stair climbing) ☐ I am currently not exercising

Tobacco Use	
In the last 30 days, have you used tobacco?	Smoked: ☐ Yes ☐ No Smokeless tobacco: ☐ Yes ☐ No
If yes to either, would you be interested in quitting tobacco use within the next month?	☐ Yes ☐ No

Alcohol Use	
In the past 7 days, on how many days did you drink alcohol?	_____ Days
On days when you drank alcohol, how often did you have (5 or more for men, 4 or more for women and those men or women 65 years old and over) alcoholic drinks on one occasion?	☐ Never ☐ Once during the week ☐ 2-3 times during the week ☐ More than 3 times during the week
Do you ever drive after drinking or ride with a driver who has been drinking?	☐ Yes ☐ No

Nutrition	
In the past 7 days, how many servings of fruit and vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, 1/2 cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball)	_____ Servings per day
In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day? (1 serving= 1 slice of 100% whole wheat bread, 1 cup of whole grain or high-fiber ready-to-eat cereal, 1/2 cup of cooked cereal such as oatmeal, or 1/2 cup of cooked brown rice or whole wheat pasta)	_____ Servings per day
In the past 7 days, how many servings of fried or high- fat foods did you typically eat each day? (examples include: fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise)	_____ Servings per day
In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?	_____ Sugar-sweetened beverages consumed per day

Seat Belt Use	
Do you always fasten your seat belt when you are in the car?	☐ Yes ☐ No

Depression	
In the past 2 weeks, how often have you felt down, depressed, or hopeless?	☐ Almost all the time ☐ Most of the time ☐ Some of the time ☐ Almost never
In the past 2 weeks, how often have you felt little interest or pleasure in doing things?	☐ Almost all the time ☐ Most of the time ☐ Some of the time ☐ Almost never
Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?	☐ Yes ☐ No
Are you actively seeing a behavioral health provider?	☐ Yes ☐ No

Anxiety	
In the past 2 weeks, how often have you felt nervous, anxious, or on edge?	☐ Almost all the time ☐ Most of the time ☐ Some of the time ☐ Almost never
In the past 2 weeks, how often were you not able to stop worrying or control your worrying?	☐ Almost all the time ☐ Most of the time ☐ Some of the time ☐ Almost never

High Stress	
How often is stress a problem for you in handling such things as: Your health?	☐ Never or rarely ☐ Sometimes ☐ Often ☐ Always
Your finances?	☐ Never or rarely ☐ Sometimes ☐ Often ☐ Always
Your family or social relationships?	☐ Never or rarely ☐ Sometimes ☐ Often ☐ Always
Your work?	☐ Never or rarely ☐ Sometimes ☐ Often ☐ Always

Social/Emotional Support	
How often do you get the social and emotional support you need?	☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Pain	
In the past 7 days, how much pain have you felt?	☐ None ☐ Some ☐ A lot

General Health	
In general, would you say your health is:	☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
How would you describe the condition of your mouth and teeth - including false teeth and dentures?	☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
Are you currently pregnant?	☐ Yes ☐ No
What is your preferred language?	_____
How would you preferred to be contacted?	☐ Mail ☐ Phone ☐ Cell ☐ Text ☐ Email

Activities of daily living	
In the past 7 days, did you need help from others to perform everyday activities such as:	☐ Eating ☐ Grooming/Bathing ☐ Using toilet ☐ Dressing ☐ Walking

Instrumental Activities of Daily Living	
In the past 7 days, did you need others to take care of things such as:	☐ Laundry ☐ Banking ☐ Using the telephone ☐ Food preparation ☐ Transportation ☐ Taking your own medications ☐ Housekeeping ☐ Shopping

Sleep	
Each night, how many hours of sleep do you usually get?	_____ Hours
Do you snore or has anyone told you that you snore?	☐ Yes ☐ No
In the past 7 days, how often have you felt sleepy during the daytime?	☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Blood Pressure	
If your blood pressure was checked within the past year, what was it when it was last checked?	☐ Low or normal (at or below 120/80) ☐ Borderline high (120/80 to 139/89) ☐ High (140/90 or higher) ☐ Don't know/not sure

Cholesterol	
If your cholesterol was checked within the past year, what was your total cholesterol when it was last checked?	☐ Desirable (below 200) ☐ Borderline high (200-239) ☐ High (240 or higher) ☐ Don't know/not sure

Blood Glucose	
If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?	☐ Desirable (below 100) ☐ Borderline high (100-125) ☐ High (126 or higher) ☐ Don't know/not sure
If diabetic, and you have had your hemoglobin A 1 c level checked in the past year, what was it the last time you had it checked?	☐ Desirable (6 or lower) ☐ Borderline high (7) ☐ High (8 or higher) ☐ Don't know/not sure

Overweight/Obesity	
What is your height without shoes?	_____ Feet _____ Inches
What is your weight?	_____ lbs.

Source: Goetzel, Ron Z., PhD, and Et Al. "Framework for a Patient-Centered Health Risk Assessment." *Framework for a Patient-Centered Health Risk Assessment*. CDC, 12 Dec. 2011. Web. 2 Feb. 2014.

Steward Health Choice Generations HMO SNP is a Health Plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in Steward Health Choice Generations HMO SNP depends on contract renewal.

This information is available in other formats, such as Braille, large print, and audio.