Health Assessment Survey

Your health is important to us. **Please take 10 minutes to complete this Health Assessment Survey and return it to the IU Health Plans Health Assessment Survey team using the enclosed prepaid, self-addressed envelope.** Based on your answers to the survey questions, we can:

- Connect you with a registered nurse care manager, if needed.
- Help you find neighborhood resources to assist with daily living.
- Discuss your health goals and develop a care plan to help you achieve them.
- Help you get the medical tests and services you may need.
- Assist caregivers or family members who may be looking after you.

Instructions

- Use blue or black ink pen only.
- Do not use pens with ink that soak through the paper.
- Make solid marks that fill the response completely.
  - **Examples**
    Correct: ■ ☑ ☒
    Incorrect: ◒ ❒
- Do not make stray marks on this form.

First name:	Last name:
Date of birth (MM/DD/YYYY):	
IU Health Plans member ID number:	

1. **Who is filling out this form?** ❑ Self ❑ Spouse ❑ Other

2. **In general, compared to other people your age, would you say your health is:**
   ❑ Poor ❑ Fair ❑ Good ❑ Very good ❑ Excellent

3. **With whom do you live?** ❑ Alone ❑ Spouse ❑ Child(ren) ❑ Other family ❑ Other

4. **What is the highest grade you completed in school?**
   ❑ Never attended
   ❑ Elementary school
   ❑ High school
   ❑ College
   ❑ Professional school

5. **In the past 12 months, how many times did you go to a doctor's office or clinic?**
   ❑ Not at all
   ❑ One time
   ❑ Two or three times
   ❑ Four to six times
   ❑ More than six times

6. **In the past 12 months, how many times have you been treated in the emergency room?**
   ❑ None
   ❑ One time
   ❑ Two or three times
   ❑ More than three times

7. **In the past 12 months, have you stayed overnight as a patient in a hospital or nursing home?**
   ❑ No
   ❑ Yes, one time
   ❑ Yes, two or three times
   ❑ Yes, more than three times

8. **How many different prescription medicines do you take on an average day?**
   (Count the number of different medicines, not the number of pills you take.)
   ❑ 0 ❑ 1 to 4 ❑ 5 to 8 ❑ 9 or more

9. **Do you need help taking the right dose of medicine at the right time?**
   ❑ Someone helps me with my medicine
   ❑ I cannot manage on my own
   ❑ No

10. What type of transportation do you use most often? *(Mark only one response)*

- ❑ I drive a car
- ❑ Walk
- ❑ Wheelchair
- ❑ Van
- ❑ Friend or relative
- ❑ Bus
- ❑ Taxi
- ❑ Other

11. In the past seven days, how many days did you exercise? ____ days

12. 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

13. Is there a friend, relative or neighbor who could take care of you for a few days if necessary?

❑ Yes ❑ No

14. Do you have a lot of difficulty with or are you completely unable to do the following daily activities?

Lifting or carrying objects as heavy as 10 pounds, such as laundry, groceries, etc.	❑ Yes	❑ No
Preparing meals every day	❑ Yes	❑ No
Managing money (e.g., keeping track of expenses or paying bills)	❑ Yes	❑ No
Walking within your home	❑ Yes	❑ No

15. In the past seven days, on how many days did you drink alcohol? days

16. Over the last two weeks, how often have you been bothered by:

Feeling nervous, anxious or not able to stop worrying?

- ❑ Nearly every day
- ❑ Half of the days
- ❑ Several days
- ❑ Not at all
- ❑ Refused
- ❑ N/A

Feeling down, depressed or hopeless?

- ❑ Nearly every day
- ❑ Half of the days
- ❑ Several days
- ❑ Not at all
- ❑ Refused
- ❑ N/A

17. In the past 12 months, has someone close to you died?

❑ Yes ❑ No

18. If yes, who have you lost? *(Mark all that apply)*

- ❑ Spouse or significant other
- ❑ Sister or other
- ❑ Child(ren)
- ❑ Other family member
- ❑ Friend(s), roommate(s)
- ❑ Pet(s)
- ❑ Other

19. Today my weight is:_____ pounds; my height is _____

20. Have you fallen in the past three months?

❑ Yes ❑ No

21. Have you and your doctor ever talked about:

Heart failure or CHF *(for example: leg swelling, water on the lungs)?*	❑ Yes	❑ No
Atrial fibrillation or irregular heart rhythm?	❑ Yes	❑ No
Heart attack?	❑ Yes	❑ No
Stroke(s)?	❑ Yes	❑ No
Emphysema or COPD?	❑ Yes	❑ No
Diabetes?	❑ Yes	❑ No
Cancer?	❑ Yes	❑ No
Amputation?	❑ Yes	❑ No
Colostomy?	❑ Yes	❑ No

22. Are you now receiving or have you had any of the following treatments? *(Mark all that apply)*

- ❑ Dialysis
- ❑ Liver transplant
- ❑ Pancreas transplant
- ❑ Cornea transplant
- ❑ Skin transplant
- ❑ Kidney transplant
- ❑ Heart transplant
- ❑ Lung transplant
- ❑ Blood thinner/anti-coagulant (Coumadin)
- ❑ Bone marrow transplant
- ❑ Stem cell transplant
- ❑ Intestine transplant
- ❑ Bone transplant
- ❑ Other transplant

23. Do you have an advance directive (living will)? ❑ Yes ❑ No

24. Have you already completed and sent a personal representative designation form to us, which gives us permission to speak with a family member, friend or caregiver regarding your care?

❑ Yes ❑ No

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