Health Risk Assessment

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

Please complete the following questions the best that you can. Your answers will not affect your Medicaid or Medicare benefits and the information will be treated with confidentiality. Information you provide may be reviewed by a care manager and may be shared with your primary care doctor and care team. Completion of this form implies that you agree to have this used for this purpose.

Required:

Full Name: _____ Date of Birth: _____

Medicaid/Medicare ID Number: _____ Phone Number: _____

Address: _____

Primary Care Physician: _____ Date: _____

Race or Ethnicity:

- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian
- ☐ Hispanic/Latino
- ☐ Native American/Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other _____
- ☐ Decline to answer

What is your preferred language:

- ☐ English
- ☐ Spanish
- ☐ Navajo
- ☐ Chinese (incl. Cantonese, Mandarin)
- ☐ Tagalog
- ☐ Vietnamese
- ☐ German
- ☐ Arabic
- ☐ Other _____

We are interested in honoring your values and beliefs. Do you have any cultural preferences we should know about that may impact your health care?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

What are your preferences? _____

Are you currently working or going to school?

- ☐ Yes, working
- ☐ Yes, going to school
- ☐ No

Level of Education

What is the highest grade or level of school that you completed?

- ☐ 8th grade or less
- ☐ Some high school
- ☐ High school graduate or GED
- ☐ Some college
- ☐ College graduate
- ☐ More than a 4-year college graduate

Contact Information

How would you prefer to be contacted?

☐ Mail ☐ Phone ☐ Cell ☐ Text ☐ Email

List contact information: _____

General Health

In general, would you say your health is:

☐ Excellent ☐ Very good ☐ Good

☐ Fair ☐ Poor

In general, would you say your dental health is:

☐ Excellent ☐ Very good ☐ Good

☐ Fair ☐ Poor

Are you currently Pregnant? ☐ Yes ☐ No

How much control do you feel you have to manage your health conditions?

☐ Always ☐ Usually ☐ Sometimes

☐ Rarely ☐ Never

Height and Weight

What is your height? _____ | What is your weight? _____

Physical Activity

Do you exercise?

☐ Yes ☐ No

How many falls have you had in the past 6 months?

☐ 1-2 ☐ 3-4 ☐ 5 or more

Activities of Daily Living & Instrumental Activities of Daily Living

In the past 7 days, did you need help from others to perform everyday activities such as:

☐ Showering ☐ Eating / Preparing to eat ☐ Dressing

☐ Getting in/out of bed, chair, or wheelchair ☐ Grooming / Bathing ☐ Shopping

☐ Using the toilet ☐ Finances ☐ Walking

☐ Housekeeping ☐ None / Don't need assistance ☐ Continence

Who, if anyone, helps you with your health care or daily living needs?

Name: _____ Phone number: _____

What do they help you with? (e.g., transportation, taking medication, emotional support, filling out forms, etc.) _____

What conditions has a doctor told you that you have or that you take medications for? Select all that apply

Cardiovascular

- ☐ Heart attack/Heart disease
- ☐ Atrial Fibrillation
- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Angina
- ☐ Heart murmur

Lungs

- ☐ Chronic bronchitis or COPD/Emphysema
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Blood clot to lung

Bone and Muscle

- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fractures

Gastroenterology

- ☐ Liver disease
- ☐ Peptic ulcer
- ☐ Bleeding

Genitourinary

- ☐ Kidney disease
- ☐ Urinary tract infection
- ☐ Kidney stones
- ☐ Prostate problem

Endocrine

- ☐ Diabetes (type I or II)
- ☐ Thyroid (high or low)
- ☐ Adrenal

Cancer

- ☐ Solid tumor (localized)
- ☐ Solid tumor (metastatic)
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Type _____

Neurology

- ☐ Stroke/CVA
- ☐ Migraine
- ☐ Seizures
- ☐ Dementia/memory loss
- ☐ TIA(Transient Ischemia Attack)

Mental Health

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Suicidal

Infectious Disease

- ☐ HIV/Aids
- ☐ Hepatitis

Other

- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Substance use disorder
- ☐ Organ Transplant
- ☐ Other_____
- ☐ None

Are there any other medical conditions that you have had in the past 5 years?

☐ Yes ☐ No

List past medical conditions you have had and when in the past 5 years:

_____

_____

_____

_____

_____

Do you take your medications as prescribed?

☐ Yes ☐ No

List your medications and their doses and schedules:

_____

_____

_____

If you don't take your medications as prescribed, what gets in the way:

_____

_____

_____

List any other medications that you took in the past 5 years, what they were for, and the outcome

_____

_____

_____

What type of equipment or services do you use?

☐ Wheelchair / Walker / Cane / Scooter	☐ Glucose monitor	☐ Bath chair
☐ C-PAP	☐ Oxygen	☐ Hoyer lift
☐ Raised toilet	☐ Hospital bed	☐ Hearing aid/s
☐ Glasses/Contact lenses	☐ Other _____	

Your Health Care in the Last 6 Months

What other providers you see besides your primary care provider?

☐ Cardiologist	☐ Endocrinologist	☐ Gynecologist
☐ Eye doctor	☐ Dentist	☐ Behavioral Health
☐ Foot doctor	☐ Neurologist	☐ Other _____

In the past 6 months, how many times have you been in the:

- Emergency Room: _____ times
- Hospital or facility overnight: _____ times

Have you had any past hospitalizations or major procedures in the past 5 years?

☐ Yes ☐ No

If yes, list: _____

Health Screening and Vaccines in the Last 5 years

If applicable, when was the last time you had any of the following screenings and who was your provider? (Month/Year)

- Breast cancer screening (mammogram): _____ Provider: _____
- Cervical cancer screening (PAP smear): _____ Provider: _____
- Colorectal cancer screening (colonoscopy, sigmoidoscopy, FIT test): _____ Provider: _____
- Prostate: _____ Provider: _____

How confident are you filling out medical forms by yourself:

☐ Extremely ☐ Quite a bit ☐ Somewhat ☐ A little bit ☐ Not at all ☐ Decline to answer

When was the last time you had any of the following vaccines?

- Pneumonia: _____
- Flu: _____
- COVID: _____
- Shingles: _____

Do you have an Advanced Directive? (A document that says how you want your healthcare delivered)

☐ Yes ☐ No

List type of Advanced Directive/s you have:

_____

_____

_____

Do you have any specific health concerns your health plan team can assist with?

☐ Yes ☐ No

If yes, please list your specific health concerns: _____

_____

_____

_____

Substance Use

Have you ever used tobacco, including vaping?

Smoked/Chewed Tobacco: ☐ Yes ☐ No

Would you be interested in quitting tobacco use within the next month?

☐ Yes ☐ No ☐ Unsure

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 4 or more alcoholic drinks on one occasion?

☐ Never ☐ Once during the week

☐ 2-3 times during the week ☐ More than 3 times during the week

Have you used any drugs or prescription drugs for non-medical reasons?

☐ Yes ☐ No

Emotional Health

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 ☐ Decline to answer

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 ☐ Decline to answer

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 ☐ Decline to answer

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 ☐ Decline to answer

Suicide Prevention Hotline Information 24/7: Call or text 988

Pain

In the past 7 days, how much pain have you felt? (Scale of 0-10)

☐ None (0) ☐ Mild (1-3) ☐ Moderate (4-6) ☐ Severe (7-10)

Describe the pain and where it is located:

_____

Food

Within the past 12 months, did you worry that your food would run out before you got money to buy more?

☐ Yes ☐ No

Housing/Utilities

Do you have housing? (Own, Rent, Apartment, Staying with family/friends)

☐ Yes ☐ No

Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed

☐ Yes ☐ NO

Transportation

Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need

☐ Yes ☐ NO

Evidenced Based Sources for HRA Development: American College of Cardiology; American Diabetes Association: Standards of Care in Diabetes; Centers for Disease Control and Prevention (CDC); Centers for Medicare & Medicaid Services (CMS); Institute of Medicine (IOM). Dietary Reference Intakes (DRIs); National Heart, Lung, and Blood Institute (NHLBI) guidelines for heart health (Adult Treatment Panel III (ATP III) Guidelines); U.S. Department of Health and Human Services. Physical Activity Guidelines for American; U.S. Department of Agriculture (USDA). Dietary Guidelines for Americans; National Institute of Health (NIH). Prevention, Detection, Evaluation, and Treatment of High Blood Pressure; American College of Preventive Medicine (ACPM); ASAM Criteria; SAMHSA. Effective 2021