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. The information will be treated with confidentiality and will help us learn more about your health needs. Information you provide may be reviewed by a care manager and may be shared with your primary care doctor, behavioral health clinic, or other members of your team. Completion of this form implies that you agree to have this used for this purpose.

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

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
- ☐ Korean
- ☐ Spanish
- ☐ Polish
- ☐ Arabic
- ☐ Portuguese
- ☐ Chinese (incl. Cantonese, Mandarin)
- ☐ Russian
- ☐ French
- ☐ Tagalog
- ☐ German
- ☐ Vietnamese
- ☐ Hindi
- ☐ Decline to answer
- ☐ Italian
- ☐ Other _____
- ☐ Japanese

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? _____

Contact Information

How would you prefer to be contacted?

☐ Mail ☐ Phone ☐ Cell ☐ Text ☐ Email

List contact information: _____

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
☐ Decline to answer

What medical conditions do you have? Select all that apply

☐ Allergic rhinitis	☐ Anticoagulation therapy	☐ Anxiety
☐ Arthritis	☐ Asthma	☐ Atrial fibrillation
☐ Autoimmune disease	☐ Benign prostatic Hypertrophy	☐ Bipolar disorder
☐ Cancer (Active)	☐ Cancer - Leukemia	☐ Cancer - Lymphoma
☐ Cancer - Solid tumor (Localized)	☐ Cancer - Solid tumor (Metastatic)	☐ Chronic Kidney disease (Mod-Severe)
☐ Chronic pain	☐ Congestive heart failure	☐ COPD/Emphysema
☐ COVID-19	☐ CVA with hemiplegia	☐ Dementia
☐ Depression	☐ Diabetes - Uncomplicated	☐ Diabetes - End organ damage
☐ Dialysis	☐ End Stage Renal Disease	☐ Fall Risk
☐ Gout	☐ Headaches	☐ Hearing problems
☐ Heart Disease	☐ Hepatitis	☐ High blood pressure
☐ High cholesterol	☐ Home oxygen	☐ Hypothyroidism
☐ Joint pain	☐ Kidney Disease - Mod-Severe	☐ Kidney failure
☐ Liver Disease - Mild	☐ Liver Disease - Mod-Severe	☐ Malaise and fatigue
☐ Migraines	☐ Neurologic disease	☐ Narcotic Use
☐ Obesity	☐ Organ transplant	☐ Osteoporosis
☐ Peripheral Neuropathy	☐ Reflux esophagitis	☐ Respiratory problems
☐ Schizophrenia	☐ Seizures	☐ Sleep apnea
☐ Sleep problems	☐ Stroke	☐ Transient ischemia attack (TIA)
☐ Urinary tract infection	☐ Vision problems	☐ None
☐ Decline to answer	☐ Other _____	

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

☐ Yes ☐ No ☐ Unsure ☐ Decline to answer

What were your past medical conditions?

_____

When did you have these past medical conditions?

_____

Do you take prescribed medications?

☐ Yes ☐ No ☐ Decline to answer

List your medications and their doses and schedules:

_____

_____

Please list any other medicines that you took in the past 5 years, what they were for and what the outcome was:

_____

_____

Are you compliant with your prescribed medications? ☐ Yes ☐ No

Why are you non-compliant with your prescribed medications?

_____

Physical Activity

In the past 7 days, how many days did you exercise?

_____ Days ☐ Decline to answer

On days when you exercised, for how long did you exercise (in minutes)?

_____ Minutes/Day ☐ N/A ☐ Decline to answer

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 ☐ Decline to answer

Are you interested in being more physically active?

☐ Not interested ☐ Yes, but not right now

☐ Yes, I'm ready ☐ Decline to answer

Tobacco Use

In the last 30 days, have you used tobacco?

Smoked: ☐ Yes ☐ No ☐ Decline to answer

Smokeless tobacco: ☐ Yes ☐ No ☐ Decline to answer

Tobacco Use

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

☐ Yes ☐ No ☐ Unsure ☐ Decline to answer

Alcohol Use

In the past 7 days, on how many days did you drink alcohol?

_____ Days ☐ Decline to answer

On days when you drank alcohol, how often did you have:

- Men under 65 years old - 5 or more alcoholic drinks on one occasion
- Men 65 years old - 4 or more alcoholic drinks on one occasion
- Women any age - 4 more alcoholic drinks on one occasion

☐ Never ☐ Once during the week

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

☐ Decline to answer

Do you ever drive after drinking or ride with a driver who has been drinking?

☐ Yes ☐ No ☐ Decline to answer

Other Substance Use

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

☐ Yes ☐ No ☐ Decline to answer

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 ☐ Decline to answer

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 ☐ Decline to answer

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, donuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise)

_____ Servings per day ☐ Decline to answer

In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?

_____ Sugar-sweetened beverages consumed per day ☐ Decline to answer

Do you want to change your eating habits to be more healthy?

☐ Not interested ☐ Yes, but not right now ☐ Yes, I'm ready

☐ Decline to answer

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 ☐ 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

Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?

☐ Yes ☐ No ☐ Decline to answer

Are you actively seeing a behavioral health provider?

☐ Yes ☐ No ☐ Decline to answer

In the past few weeks, have you wished you were dead?

☐ Yes ☐ No ☐ Decline to answer

In the past few weeks, have you felt that you or your family would be better off if you were dead?

☐ Yes ☐ No ☐ Decline to answer

Suicide Prevention Hotline Information:
24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
24/7 Crisis Text Line: Text "HOME" to 741-741

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 ☐ 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

High Stress

How often is stress a problem for you in handling such things as:

Your health?

☐ Never or rarely ☐ Sometimes ☐ Often
☐ Always ☐ Decline to answer

Your finances?

☐ Never or rarely ☐ Sometimes ☐ Often
☐ Always ☐ Decline to answer

Your family or social relationships?

☐ Never or rarely ☐ Sometimes ☐ Often
☐ Always ☐ Decline to answer

Your work?

☐ Never or rarely ☐ Sometimes ☐ Often
☐ Always ☐ Not working/Retired ☐ Decline to answer

Social/Emotional Support

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes
☐ Rarely ☐ Never ☐ Decline to answer

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) ☐ Decline to answer

Describe the pain and where it is located:

_____

General Health

In general, would you say your health is:

☐ Excellent ☐ Very good ☐ Good
☐ Fair ☐ Poor ☐ Decline to answer

How would you describe the condition of your mouth and teeth - including false teeth and dentures?

☐ Excellent ☐ Very good ☐ Good
☐ Fair ☐ Poor ☐ Decline to answer

Are you currently pregnant?

☐ Yes ☐ No ☐ Unknown
☐ Not applicable ☐ Decline to answer

How confident are you filling out medical forms by yourself?

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

Activities of Daily Living

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

☐ Continence ☐ Dressing ☐ Eating
☐ Getting in/out of bed, chair or wheelchair ☐ Grooming/Bathing ☐ Using toilet
☐ Walking ☐ None-Don't need assistance ☐ Declined to answer

Instrumental Activities of Daily Living

In the past 7 days, did you need help from others to take care of things such as:

☐ Banking ☐ Food preparation ☐ Housekeeping
☐ Laundry ☐ Shopping ☐ Taking your own medications
☐ Transportation ☐ Using the telephone ☐ None-Don't need assistance
☐ Declined to answer

Sexual Health

Do you use protection such as condoms during sex?

☐ Yes ☐ No ☐ Sometimes ☐ Decline to answer

Do you take medications for sexually transmitted disease?

If so, what is it? _____

☐ Yes ☐ No ☐ Decline to answer

Social and Other Needs

Are you a Veteran?

☐ Yes ☐ No ☐ Decline to answer

Food

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

☐ Yes ☐ No ☐ Decline to answer

Within the past 12 months, did the food you bought just not last and you didn't have money to get more?

☐ Yes ☐ No ☐ Decline to answer

Housing/Utilities

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

☐ Yes ☐ No ☐ Decline to answer

Are you worried about losing your housing?

☐ Yes ☐ No ☐ Decline to answer

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 ☐ Decline to answer

Work

During the past 4 weeks, has your health impacted your ability to work or caused you to be absent from activities you enjoy?

☐ Not at all ☐ A little bit ☐ Moderately

☐ Quite a bit ☐ Extremely ☐ Decline to answer

☐ Retired/Not working

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 ☐ Decline to answer

Interpersonal Safety

Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No ☐ Decline to answer

Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

☐ Yes ☐ No ☐ Decline to answer

Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?

☐ Yes ☐ No ☐ Decline to answer

Do you always fasten your seat belt when you are in the car?

☐ Yes ☐ No ☐ Decline to answer

Sleep

Each night, how many hours of sleep do you usually get? _____ ☐ Decline to answer

Do you snore, or has anyone told you that you snore?

☐ Yes ☐ No ☐ Decline to answer

In the past 7 days, how often have you felt sleepy during the daytime?

☐ Always ☐ Usually ☐ Sometimes

☐ Rarely ☐ Never ☐ Decline to answer

Blood Pressure

If your blood pressure was checked within the past year, what was it when it was last checked?

☐ Low (at or below 120/80) ☐ Borderline (121/81 to 139/89) ☐ High (140/90 or higher)

☐ Don't know/not sure ☐ Decline to answer

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 ☐ Decline to answer

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 (100-125) ☐ High (126 or higher)

☐ Don't know/not sure ☐ Decline to answer

If diabetic, and you have had your hemoglobin A1c 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 ☐ Not Diabetic ☐ Decline to answer

☐ Diabetic but have not been tested in the last year

Height and Weight

What is your height? _____ ☐ Decline to answer | What is your weight? _____ ☐ Decline to answer

Do you want to work on getting to a healthy weight?

☐ I'm already at a healthy weight ☐ Not interested ☐ Yes, but not right now

☐ Yes, I'm ready ☐ Decline to answer

Your Health Care in the Last 6 Months

What is the name of your Primary Care Physician or Clinic? _____

Using any number from 0 to 10, where 0 is the worst and 10 is the best, what number would you use to rate your Primary Care Physician or Clinic? Please circle your response.

Worst Neutral Best

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) ☐ Decline to answer

Are you actively participating in services at a Behavioral Health Home or Clinic?

☐ Yes ☐ No ☐ Decline to answer

What is the name of your Behavioral Health Home or Clinic? _____

Using any number from 0 to 10, where 0 is the worst and 10 is the best, what number would you use to rate your Behavioral Health Home or Clinic? Please circle your response.

Worst Neutral Best

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) ☐ Decline to answer

In the past 6 months, how many times did you visit the Emergency Department?

☐ None ☐ 1 time ☐ 2-3 times

☐ 4-5 times ☐ 6 or more times ☐ Decline to answer

In the past 6 months, how many times did you have to stay overnight (one or more nights) at any hospital?

☐ None ☐ 1 time ☐ 2-3 times

☐ 4-5 times ☐ 6 or more times ☐ Decline to answer

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

☐ Yes ☐ No ☐ Unsure ☐ Decline to answer

What were your hospitalizations/procedures, and what were they for?

_____

_____

When were these past hospitalizations/procedures?

_____

_____

When was the last time you had a breast cancer screening (mammogram)?

☐ In the last year ☐ In the last 2-4 years ☐ In the last 5 years

☐ Greater than 5 years ☐ Never ☐ Not applicable

☐ Do not remember when ☐ Decline to answer

Your Health Care in the Last 6 Months

When was the last time you had a colorectal cancer screening (colonoscopy, sigmoidoscopy, or FIT test)?

☐ In the last year ☐ In the last 2-4 years ☐ In the last 5 years
☐ Greater than 5 years ☐ Never ☐ Not applicable
☐ Do not remember when ☐ Decline to answer

When was the last time you had a cervical cancer screening (PAP smear)?

☐ In the last year ☐ In the last 2-4 years ☐ In the last 5 years
☐ Greater than 5 years ☐ Never ☐ Not applicable
☐ Do not remember when ☐ Decline to answer

When was the last time you had a pneumonia vaccine?

☐ In the last year ☐ In the last 2-4 years ☐ In the last 5 years
☐ Greater than 5 years ☐ Never ☐ Not applicable
☐ Do not remember when ☐ Decline to answer

Have you had a flu shot this year or are you planning to receive one this year?

☐ Yes ☐ No ☐ Decline to answer

Have you had a COVID vaccination?

☐ Yes ☐ No ☐ Decline to answer

Have you had Monoclonal antibody treatment? (only administered if positive for COVID-19)

☐ Yes ☐ No ☐ Decline to answer

Do you have an Advanced Directive?

☐ Yes ☐ No ☐ Decline to answer

Which type?

☐ Living Will ☐ Health care proxy ☐ Durable power of attorney
☐ Behavioral health power of attorney ☐ MOLST/POLST
☐ Unsure which on ☐ Other: _____

Do you have any specific health concerns your health plan team can assist with? Interdisciplinary Care Team (ICT) is an important component of your integrated care program. The ICT can consist of you, your provider, other specialist, care manager, family members, medical director, and behavioral health professionals as needed to develop your care plan. Would you like to participate in the ICT?

☐ Yes ☐ No ☐ Decline to answer

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 2019-2020