hmsa

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HMSA Akamai Advantage Dual Care
HEALTH RISK ASSESSMENT

Member name: _____ **Date of birth:** _____

Street address: _____ City: _____ State: _____ ZIP code: _____

Mailing address: _____ City: _____ State: _____ ZIP code: _____

Phone number: _____ Email address: _____

Primary care provider last visit: _____ Next scheduled visit: _____

PCP name: _____ **Completion date:** _____

Completed by: _____

Relationship to member: ☐ Self ☐ Member's representative ☐ HMSA staff Other: _____

Best day and time to call: _____ Do you prefer text/email: _____

Primary language: _____

Method of completion: ☐ Telephone ☐ Mail ☐ Fax ☐ Other: _____

GENERAL HEALTH	
1. How's your overall health?	☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Do you have a dentist who you see every six months?	☐ Yes ☐ No
3. Are you taking your medications as prescribed?	☐ Yes ☐ No ☐ Not on any medications
4. Do you have reliable transportation for your medical appointments and to pick up your medications?	☐ Yes ☐ No ☐ Sometimes, but it's not reliable
5. In the last six months, how many times have you been to the ER or hospitalized?	☐ 0 ☐ 1-2 ☐ 3 or more
6. Do you use the following? (Select all that apply)	☐ Tobacco ☐ Cigarettes ☐ Smokeless tobacco ☐ Vapes ☐ E-cigarettes ☐ N/A or none
7. Do you drink any alcohol products?	☐ Yes ☐ No
8. Do you use any other substance(s)?	☐ Yes ☐ No
9. If you answered "Yes" to questions #6-8, would you be interested in learning how to reduce your use of these substances?	☐ Yes ☐ No
10. Did you receive the flu vaccine for this flu season?	☐ Yes ☐ No
11. Did you receive the COVID-19 vaccine?	☐ Yes ☐ No
12. Date(s) that you received the COVID-19 vaccine	

HEALTH CONDITIONS	
13. What health conditions do you have?	☐ Bipolar disorder or schizophrenia ☐ Cancer ☐ Chronic obstructive pulmonary disease ☐ Dementia ☐ Diabetes ☐ Heart failure ☐ Hypertension ☐ Kidney disease ☐ Liver disease ☐ Stroke ☐ None

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14. Have you had a mammogram recently?	☐ Yes ☐ No Date (or year) _____ Name of clinic or location _____
15. Have you had a colon cancer screening recently?	☐ Yes ☐ No Date (or year) _____ Name of clinic or location _____ Type of test ☐ FOBT/FIT test ☐ Flexible sigmoidoscopy ☐ Colonoscopy
16. What health care goals are important to you?	

HOME/SAFETY			
17. What's your living situation today?	☐ I have a steady place to live ☐ I have a place to live today, but I'm worried about losing it in the future		☐ I don't have a steady place to live
18. Who do you live with?	☐ I live alone ☐ I don't have a place to live ☐ Nursing home or assisted living facility/home		☐ With a friend or roommate ☐ With my spouse or other family ☐ Other
Sensory ability			
19. Do you use glasses or contact lenses?	☐ Yes	☐ No	☐ I don't know
20. Do you use a hearing aid?	☐ Yes	☐ No	☐ I don't know

FOOD			
21. Do you receive any financial assistance, such as EBT/Food stamps, SSI, SSDI?	☐ Yes	☐ No	
22. Within the past 12 months, have you worried that your food would run out before you got money to buy more?	☐ Often true	☐ Never true	☐ Sometimes true
23. Within the past 12 months, did you run out of food and didn't have money to buy more?	☐ Often true	☐ Never true	☐ Sometimes true

FUNCTIONAL STATUS ASSESSMENT		
Instrumental activities of daily living		
24. Which of the following can you do without help?	☐ Drive/use public transportation ☐ Handle finances ☐ Housework ☐ Cook a meal	☐ Shop for groceries ☐ Take medications ☐ Use the telephone ☐ None

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Activities of daily living			
25. Which of the following do you need help with?	☐ Bathe ☐ Eat	☐ Get dressed ☐ Get in and out of chairs	☐ Walk ☐ Use the restroom ☐ None

Ambulation status			
26. How long can you walk or move around?	☐ Less than 5 minutes ☐ 5-15 minutes ☐ 15-30 minutes		☐ More than 1 hour ☐ I can't walk or move around ☐ I don't know
27. Do you use any of the following assisted devices? (Select all that apply)	☐ Cane ☐ Crutches	☐ Walker ☐ Wheelchair	☐ Other ☐ None
28. Do you have trouble with your balance?	☐ Yes	☐ No	
29. How many times have you fallen within the last six months?	☐ 0	☐ 1-2 times	☐ 3 or more times
30. Do you have problems remembering things?	☐ Yes	☐ No	

PAIN ASSESSMENT

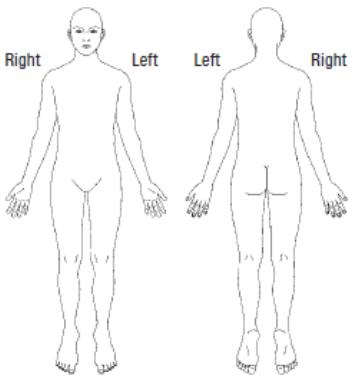
31. In the past two weeks, how often have you felt pain?

- ☐ Almost all the time
- ☐ Most times
- ☐ Sometimes
- ☐ Almost never
- ☐ No pain

32. Where's the pain? Any other locations?

Mark all areas on the images or

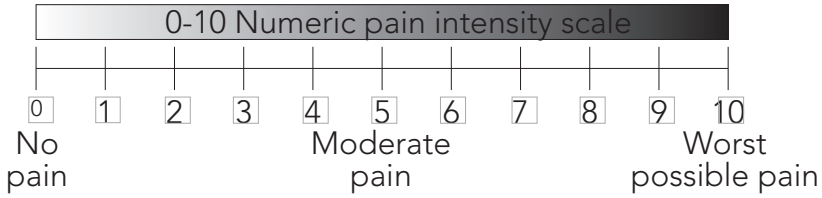
☐ No pain



33. How do you treat the pain?

- ☐ Medication
- ☐ Rest
- ☐ Heat or cold compress
- ☐ Therapy
- ☐ Other
- ☐ No treatment plan
- ☐ No pain

34. Rate your pain on a scale of 0-10 with 0 being no pain and 10 being the worst pain:



ADVANCE DIRECTIVES

35. Do you have a health care power of attorney or a living will?	☐ Yes	☐ No	☐ I don't know
36. Would you like more information?	☐ Yes	☐ No	

OFFICIAL USE ONLY

☐ Initial assessment ☐ Annual assessment ☐ Interim assessment