

# Health Care Assessment Form



Now that you are a member of Passport Advantage HMO SNP, we ask that you please fill out this form. It will help us see how we can best serve you with our benefits and special programs. If you need help completing this form, please call 1-800-578-0603, press 0, then press 78227.

**Name (first)** \_\_\_\_\_ **(middle initial)** \_\_\_\_\_ **(last)** \_\_\_\_\_

**Address** \_\_\_\_\_ **Apt #** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Daytime Phone** \_\_\_\_\_ **Date of birth** \_\_\_\_\_

**Last four digits of your Social Security #:** \_\_\_\_\_

**Signature** \_\_\_\_\_

**What is the name of the doctor you see the most?** \_\_\_\_\_

**What is your doctor's phone number?** \_\_\_\_\_

**What is your preferred language?**

- English     Spanish     Arabic     Vietnamese     Bosnian  
 Russian     French     German     Sign     Other \_\_\_\_\_

**What is your gender?**     Male     Female

**When was your last physical exam?** \_\_\_\_\_

## Section One

1 2 3 4 5	1. In general, would you say your health is: (circle one number) 1 - Excellent 2 - Very Good 3 - Good 4 - Fair 5 - Poor
1 2 3 1 2 3	The following are activities you might do during a normal day. Please circle one of the numbers to describe how much your health limits you in any of these activities. 1 - Yes, limited a lot 2 - Yes, limited a little 3 - No, not limited (circle one number on each line) 2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf. 3. Climbing several flights of stairs.
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? 4. Accomplished less than you would like. 5. Were limited in the kind of work or other activities.
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? 6. Accomplished less than you would like. 7. Did not do work or other activities as carefully as usual.
1 2 3 4 5	8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? 1 - Not at all 2 - Slightly 3 - Moderately 4 - Quite a bit 5 - Extremely (circle one number)
1 2 3 4 5 6 1 2 3 4 5 6 1 2 3 4 5 6	These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. 1 - All of the time 2 - Most of the time 3 - A good bit of the time 4 - Some 5 - A little of the time 6 - None of the time How much of the time during the past 4 weeks ... (circle one number on each line) 9. Have you felt calm and peaceful? 10. Did you have a lot of energy? 11. Have you felt downhearted and blue?
1 2 3 4 5 6	12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (such as visiting with friends, relatives, etc)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Have you seen a psychiatrist or any other mental/emotional health provider previously?
<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Have you ever been in a psychiatric facility?
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Are you on any behavioral health medications? If yes, what are they? _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Have you ever been treated for substance abuse (alcohol, drugs)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Do you have a current need for help getting a counselor, therapist, or psychiatrist?
<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Do you have a current need for getting food, clothing or housing?



**Women Only**

1 2 3 4 5 6

**(If your age is 40 or over)**

4. How long has it been since your last mammogram? (a test for breast cancer)
- 1 – Less than 1 year ago.
  - 2 – 1 year ago
  - 3 – 2 years ago.
  - 4 – 3 or more years ago
  - 5 – Never
  - 6 – I have had both breasts removed

1 2 3 4 5 6

**(If your age is 21 and over)**

5. How long has it been since you had a Pap smear? (test for cervical cancer)
- 1 – less than 1 year ago.
  - 2 – 1 year ago
  - 3 – 2 years ago
  - 4 – 3 or more years ago
  - 5 – Never
  - 6 – I have had a hysterectomy

**Men Only**

1 2 3 4 5

6. About how long has it been since you had a rectal or prostate exam?
- 1 – less than 1 year ago
  - 2 – 1 year ago
  - 3 – 2 years ago
  - 4 – 3 or more years ago
  - 5 – Never

**Thank you for completing the Health Care Assessment!**

Please mail this back in the white postage-paid envelope we sent you, or to the following address:

Passport Advantage  
Attn: Health Care Assessment  
305 W. Broadway, 3rd Floor  
Louisville, KY 40202