HEALTH APPRAISAL

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. Any questions that you are not comfortable answering, mark "Decline to answer." 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
- ☐ Other: _____
- ☐ German
- ☐ Arabic

Sex Assigned at Birth:

- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Decline to answer

Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Transgender male\trans man\ female-to-male (FTM)
- ☐ Transgender female\trans woman\ male-to-female (MTF)
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Additional gender category or other: _____
- ☐ Two-Spirit
- ☐ Don't know
- ☐ Decline to answer

Pronouns:

- ☐ He\Him
- ☐ She\Her
- ☐ Don't know
- ☐ Other: _____
- ☐ Decline to answer

Sexual Orientation:

- ☐ Lesbian, gay, or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Don't know
- ☐ Something else, describe: _____
- ☐ Decline to answer

We Are Interested In Honoring Your Values and Beliefs. Do You Have Any Cultural Preferences We Should Know About That May Impact Your Healthcare?

☐ Yes ☐ No ☐ Decline to answer

What are your preferences? _____

Are You Currently Working or Going to School?

☐ Yes, working ☐ Yes, going to school ☐ No ☐ Decline to answer

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

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 physical health is:

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

In general, would you say your mental health is:

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

In general, would you say your dental health is:

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

Are you currently pregnant?

☐ Yes ☐ No ☐ Decline to answer

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

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

Height and Weight

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

Physical Activity

Do you exercise?

☐ Yes ☐ No ☐ Decline to answer

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

☐ None ☐ 1-2 ☐ 3-4

☐ 5 or more ☐ Decline to answer

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, household chores ☐ None / Don't need assistance ☐ Continence

☐ Decline to answer

Who, if anyone, helps you with your healthcare 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.

- ☐ Adrenal
- ☐ Peripheral neuropathy
- ☐ Heart attack/Heart disease
- ☐ Anxiety
- ☐ PTSD
- ☐ Heart murmur
- ☐ Asthma
- ☐ Seizures
- ☐ High blood pressure
- ☐ Bipolar
- ☐ Stroke/CVA
- ☐ HIV/Aids
- ☐ Blood clot to lung
- ☐ Suicidal
- ☐ Kidney stones
- ☐ Cancer solid tumor (metastatic)
- ☐ TIA (Transient Ischemia Attack)
- ☐ Liver disease
- ☐ Dementia/memory loss
- ☐ Vision Problems
- ☐ Migraines
- ☐ Diabetes (type I or II)
- ☐ None
- ☐ Osteoporosis
- ☐ GERD/Reflux esophagitis
- ☐ Hearing problems
- ☐ Angina
- ☐ Prostate problem
- ☐ Heart failure
- ☐ Arthritis
- ☐ Schizophrenia
- ☐ Hepatitis
- ☐ Atrial fibrillation
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ Bleeding
- ☐ Substance use disorder
- ☐ Kidney disease
- ☐ Cancer solid tumor (localized)
- ☐ Thyroid (high or low)
- ☐ Leukemia
- ☐ Chronic bronchitis or COPD/Emphysema
- ☐ Urinary tract infection
- ☐ Lymphoma
- ☐ Depression
- ☐ Organ transplant
- ☐ Fractures
- ☐ Peptic ulcer
- ☐ Other: _____
- ☐ Decline to answer

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 ☐ No medications prescribed ☐ Decline to answer

List the medications you have been prescribed along with their doses and frequency:

_____

_____

_____

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?

Equipment

☐ Wheelchair / Walker / Cane / Scooter ☐ Glucose monitor ☐ Bath chair

☐ C-PAP ☐ Oxygen ☐ Hoyer lift

☐ Raised toilet ☐ Hospital bed ☐ Hearing aid/s

☐ Other: _____ ☐ Glasses / Contact lenses ☐ Decline to answer

Your Healthcare In The Last 6 Months

What other providers do you see besides your primary care provider?

☐ Cardiologist ☐ Endocrinologist ☐ Gynecologist

☐ Eye doctor ☐ Dentist ☐ Behavioral Health

☐ Foot doctor ☐ Neurologist ☐ Urologist

☐ Other: _____ ☐ Decline to answer

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

- Emergency Room: _____ times
- Hospital or facility overnight: _____ times ☐ Decline to answer

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

☐ Yes ☐ No

If yes, list: _____

Interpersonal Safety

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

☐ Yes ☐ No ☐ Decline to answer

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: _____ ☐ Decline to answer
- Flu: _____ ☐ Decline to answer
- COVID: _____ ☐ Decline to answer
- Shingles: _____ ☐ Decline to answer

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

☐ Yes ☐ No ☐ Decline to answer

List type of Advance Directive/s you have:

_____

_____

_____

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

☐ Yes ☐ No ☐ Decline to answer

If yes, please list your specific health concerns: _____

_____

_____

_____

The 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

Substance Use

Have you used tobacco, including vaping, in the past 6 months?

☐ Yes ☐ No ☐ Decline to answer

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

☐ Yes ☐ No ☐ Unsure ☐ Decline to answer

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 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

☐ Decline to answer

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

☐ Yes ☐ No ☐ Decline to answer

Emotional Health

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

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

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:

_____

Please indicate how often this describes you:

I don't have enough money to pay my bills:

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

☐ Always ☐ Decline to answer

Food

Within the past 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

☐ Yes ☐ No ☐ Decline to answer

Housing/Utilities

Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as a part of a household?

☐ Yes ☐ No ☐ Decline to answer

In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?

☐ Yes ☐ No ☐ Decline to answer

Transportation

In the last 6 months, have you ever had to go without healthcare because you didn't have a way to get there?

☐ 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 Americans; U.S. Department of Agriculture (USDA). Dietary Guidelines for Americans; National Institutes of Health (NIH). Prevention, Detection, Evaluation, and Treatment of High Blood Pressure; American College of Preventive Medicine (ACPM); ASAM Criteria; SAMHSA; Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE); Health Leads Screening Toolkit; American Hospital Association (AHA): NCQA; Health Leads Screening. Effective 2023.