



## Medicare Health Risk Assessment Questionnaire

| Enrollee Information                                                                                                                                                                                                                            |                                    |                                    |                                               |                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------|-----------------------------------------------|-------------------------------|
| Name:                                                                                                                                                                                                                                           |                                    | Date of Birth (MM/DD/YYYY):        |                                               |                               |
| Gender:                                                                                                                                                                                                                                         | <input type="checkbox"/> Female    | <input type="checkbox"/> Male      | <input type="checkbox"/> Prefer not to answer |                               |
| Preferred Language:                                                                                                                                                                                                                             | <input type="checkbox"/> English   | <input type="checkbox"/> Spanish   | <input type="checkbox"/> Other                |                               |
| Ethnicity:                                                                                                                                                                                                                                      |                                    |                                    |                                               |                               |
| <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Pacific Islander/Native Hawaiian                                                                                        |                                    |                                    |                                               |                               |
| <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Other                                                                                                                           |                                    |                                    |                                               |                               |
| <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> I prefer not to answer                                                                                                                       |                                    |                                    |                                               |                               |
| Preferred Method of Contact:                                                                                                                                                                                                                    |                                    | <input type="checkbox"/> Phone     | <input type="checkbox"/> MyChart              |                               |
| How would you rate your overall health:                                                                                                                                                                                                         | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good      | <input type="checkbox"/> Fair                 | <input type="checkbox"/> Poor |
| How much do you need help with the following:                                                                                                                                                                                                   |                                    |                                    |                                               |                               |
| Bathing                                                                                                                                                                                                                                         | <input type="checkbox"/> No help   | <input type="checkbox"/> Some help | <input type="checkbox"/> Can't do at all      |                               |
| Eating                                                                                                                                                                                                                                          | <input type="checkbox"/> No help   | <input type="checkbox"/> Some help | <input type="checkbox"/> Can't do at all      |                               |
| Preparing meals                                                                                                                                                                                                                                 | <input type="checkbox"/> No help   | <input type="checkbox"/> Some help | <input type="checkbox"/> Can't do at all      |                               |
| Using the bathroom                                                                                                                                                                                                                              | <input type="checkbox"/> No help   | <input type="checkbox"/> Some help | <input type="checkbox"/> Can't do at all      |                               |
| Dressing                                                                                                                                                                                                                                        | <input type="checkbox"/> No help   | <input type="checkbox"/> Some help | <input type="checkbox"/> Can't do at all      |                               |
| Getting out of bed or chair                                                                                                                                                                                                                     | <input type="checkbox"/> No help   | <input type="checkbox"/> Some help | <input type="checkbox"/> Can't do at all      |                               |
| Taking medications                                                                                                                                                                                                                              | <input type="checkbox"/> No help   | <input type="checkbox"/> Some help | <input type="checkbox"/> Can't do at all      |                               |
| Walking                                                                                                                                                                                                                                         | <input type="checkbox"/> No help   | <input type="checkbox"/> Some help | <input type="checkbox"/> Can't do at all      |                               |
| If you need help with any of the above, do you have someone close by or a caregiver who helps you?                                                                                                                                              |                                    |                                    |                                               |                               |
| <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Caregiver <input type="checkbox"/> No Help Needed <input type="checkbox"/> No Support <input type="checkbox"/> Other |                                    |                                    |                                               |                               |
| Do you need help finding a Primary Care Physician:                                                                                                                                                                                              |                                    |                                    | <input type="checkbox"/> Yes                  | <input type="checkbox"/> No   |
| Do you need help finding a mental health specialist:                                                                                                                                                                                            |                                    |                                    | <input type="checkbox"/> Yes                  | <input type="checkbox"/> No   |

|                                                                                                                                                                                                                                                                                                                                                                                                                                               |                              |                             |                                                                            |                              |                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|----------------------------------------------------------------------------|------------------------------|-----------------------------|
| <b>What is your housing situation today:</b><br><input type="checkbox"/> I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)<br><input type="checkbox"/> I have housing today, but I am worried about losing housing in the future.<br><input type="checkbox"/> I have housing                             |                              |                             |                                                                            |                              |                             |
| <b>Within the past 12 months, the food you bought just didn't last and you didn't have money to get more?</b><br><input type="checkbox"/> Often true <input type="checkbox"/> Sometimes true <input type="checkbox"/> Never true                                                                                                                                                                                                              |                              |                             |                                                                            |                              |                             |
| <b>In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or getting things needed for daily living? (check all that apply)</b><br><input type="checkbox"/> Yes, it has kept me from medical appointments or getting medications.<br><input type="checkbox"/> Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need.<br><input type="checkbox"/> No |                              |                             |                                                                            |                              |                             |
| <b>In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already shut off                                                                                                                                                                                                                |                              |                             |                                                                            |                              |                             |
| <b>Do you feel physically and emotionally safe where you currently live?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer                                                                                                                                                                                                                                                        |                              |                             |                                                                            |                              |                             |
| <b>Do you have dependable internet? (Your internet works well, and stays connected)</b>                                                                                                                                                                                                                                                                                                                                                       |                              |                             |                                                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Do you have a smartphone or a computer with a camera and a microphone?</b>                                                                                                                                                                                                                                                                                                                                                                 |                              |                             |                                                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Can you download a mobile application or "app" and change browser or camera settings on a computer or smartphone?</b>                                                                                                                                                                                                                                                                                                                      |                              |                             |                                                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Would you like assistance or resources to learn more about scheduling telemedicine/virtual visits?</b>                                                                                                                                                                                                                                                                                                                                     |                              |                             |                                                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                                                                                                                                                                                                                                                                                                                                                                                                                                               |                              |                             |                                                                            |                              |                             |
| <b>Have you ever been diagnosed by a provider with any of the following?</b>                                                                                                                                                                                                                                                                                                                                                                  |                              |                             |                                                                            |                              |                             |
| Shortness of Breath                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cardiovascular Disease/Coronary Artery Disease/Peripheral Vascular Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congestive Heart Failure                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | COPD/Lung Disease                                                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Frequent Falls                                                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Disease                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's                                                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Multiple Sclerosis                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dementia/Alzheimer's                                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy/Seizures                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vision Loss                                                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing Loss                                                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Organ Transplant (kidney, liver, etc)                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Quadriplegic/Paraplegic                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Depression                                                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Amputee                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anxiety                                                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

|                                                                                                                                                                                                                                            |                              |                             |                    |                              |                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| Cancer                                                                                                                                                                                                                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Non-healing wounds | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                                                                                                                                                                                                                                            |                              |                             |                    |                              |                             |
| Do you currently use nicotine products? (smoking, vaping, chew, etc)                                                                                                                                                                       |                              |                             |                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, would you like more information or resources on quitting?                                                                                                                                                                          |                              |                             |                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you receive the flu vaccine annually?                                                                                                                                                                                                   |                              |                             |                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have an advanced healthcare directive?                                                                                                                                                                                              |                              |                             |                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If no, would you like more information on advanced healthcare directives?                                                                                                                                                                  |                              |                             |                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>In an average week, how many alcoholic drinks do you consume?</b><br><input type="checkbox"/> 1-7 Drinks <input type="checkbox"/> 8-14 Drinks <input type="checkbox"/> More than 15 <input type="checkbox"/> I do not drink             |                              |                             |                    |                              |                             |
| <b>Do you take your medications as prescribed? Please mark all that apply.</b><br><input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> I do not take any medications |                              |                             |                    |                              |                             |
| In the last 6 months, have you ever needed to cut your pills in half to make them last longer?                                                                                                                                             |                              |                             |                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>How many medications are you currently prescribed?</b><br><input type="checkbox"/> 0 <input type="checkbox"/> 1-4 <input type="checkbox"/> 5-9 <input type="checkbox"/> More than 10                                                    |                              |                             |                    |                              |                             |
| <b>In the last 12 months, how many times have you been to the emergency room?</b><br><input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> More than 3                                 |                              |                             |                    |                              |                             |
| <b>In the last 12 months, how many times have you been admitted to the hospital?</b><br><input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> More than 3                              |                              |                             |                    |                              |                             |

If you would like more information about our Care Management programs, please contact us at 1-855-962-7325 Monday through Friday from 8:00 am – 5:00 pm. As a member of Peak Advantage, you also have 24/7 access to a registered nurse for medical advice at 1-844-484-0307.