Health Risk Assessment (HRA)

MEMORIAL HERMANN Health Plan

First Name: _____ Last Name: _____ Gender: M ___ F

Address: _____ Email: _____ Date of Birth: _____

_____ Phone #: _____ Provider Name: _____

Please select one answer for each question and return to Memorial Hermann Health Plan.

1. In general how would you rate your health? ___ Good ___ Fair ___ Poor
2. Do you live: ___ Alone ___ With spouse ___ With other family member ___ With a non-relative
   ___ Nursing home or assisted living facility
3. Are you on a special diet? ___ No ___ Yes, explain: _____
4. What is your height? ___ ft. ___ in. What is your weight? ____ lbs.
5. Do you exercise regularly or take part in an exercise program? ___No ___ Yes, daily ___ Yes, 3 times a week
6. Are you a smoker? ___ No ___ Yes, but I'd like to quit ___ Yes, but I'm not ready to quit
7. Do you consume alcohol? ___ Yes ___ No
8. On a typical week, how often do you have 5 or more alcoholic drinks on one occasion?
   ___ Never ___ Once a week ___ 2-3 times per week ___ More than 3 times per week
9. Have you ever thought of reducing the amount of alcohol you consume? ___ Yes ___ No ___ N/A
10. Over the last 2 weeks have you had little interest or pleasure doing things you would normally do?
    ___ Not at all ___ Twice a week __ Four times a week ___Nearly everyday
11. In the past two weeks have you been feeling downhearted, depressed, or blue?
    ___ Not at all ___ Twice a week __ Four times a week ___Nearly everyday
12. How often do you get the social and emotional support you need: ___Always ___Sometimes ___Never
13. How many prescriptions do you take per day? ___ 5 or less ___ 6-10 ___ 11-19 ___ 20+
14. Do you have problems taking your medications prescribed by your doctor?
    ___ Yes, all the time ___ Yes, but only sometimes ___ No, not at all
15. What level of difficulty do you have doing the following activities?

a. Eating/Preparing meals	___ No Difficulty	___ Some Difficulty	___ Unable to do/Need help
b. Walking	___ No Difficulty	___ Some Difficulty	___ Unable to do/Need help
c. Getting up from a sitting position	__ No Difficulty	___ Some Difficulty	___ Unable to do/Need help
d. Organizing your day	___ No Difficulty	___ Some Difficulty	___ Unable to do/Need help
e. Dressing	___ No Difficulty	___ Some Difficulty	___ Unable to do/Need help
f. Taking medications	___ No Difficulty	___ Some Difficulty	Unable to do/Need help
g. Bathing/Toileting	___ No Difficulty	___ Some Difficulty	___ Unable to do/Need help
h. Driving	___ No Difficulty	___ Some Difficulty	___ Unable to do/Need help
i. Housekeeping	___ No Difficulty	___ Some Difficulty	___ Unable to do/Need help
j. Getting in/out of bed	___ No Difficulty	___ Some Difficulty	___ Unable to do/Need help

Please Turn Over

16. In the past 12 months, have you received the following?

a. Flu Vaccine	___ Yes	___ No	___ No, doctor advised against it	
b. Eye Exam	___ Yes	___ No	___ No, doctor advised against it	
c. Blood in Stool Test	___ Yes	___ No	___ No, doctor advised against it	
d. Pneumonia Vaccine	___ Yes	___ No	___ No, doctor advised against it	
e. Shingles Vaccine	___ Yes	___ No	___ No, doctor advised against it	
f. Whooping Cough Vaccine	___ Yes	___ No	___ No, doctor advised against it	
g. Colonoscopy	___ Yes	___ No	___ No, doctor advised against it	
h. Sigmoidoscopy	___ Yes	___ No	___ No, doctor advised against it	
i. Mammogram	___ Yes	___ No	___ No, doctor advised against it	___ N/A
j. Prostate Exam	___ Yes	___ No	___ No, doctor advised against it	___ N/A

17. Have you ever been or are currently being treated for any of the following medical conditions?

a. Asthma	___ Yes	___Yes, in the past but no longer	___ No
b. Cancer	___ Yes	___Yes, in the past but no longer	___ No
• Specify Type: _____			
c. Diabetes	___ Yes	___Yes, in the past but no longer	___ No
d. Depression/Anxiety	___ Yes	___Yes, in the past but no longer	___ No
e. Hepatitis	___ Yes	___Yes, in the past but no longer	___ No
f. Kidney Failure/Disease	___ Yes	___Yes, in the past but no longer	___ No
g. High Blood Pressure/Hypertension	___ Yes	___Yes, in the past but no longer	___ No
h. Congestive Heart Failure	___ Yes	___Yes, in the past but no longer	___ No
i. COPD/Emphysema	___ Yes	___Yes, in the past but no longer	___ No
j. Stroke	___ Yes	___Yes, in the past but no longer	___ No
k. Vision Issues	___ Yes	___Yes, in the past but no longer	___ No
l. Hearing Issues	___ Yes	___Yes, in the past but no longer	___ No

18. Have you ever used or currently using any of the following equipment?

a. Oxygen	___ No	___ Have in the past	___ Yes
b. C-PAP	___ No	___ Have in the past	___ Yes
c. Nebulizer	___ No	___ Have in the past	___ Yes
d. Walker	___ No	___ Have in the past	___ Yes
e. Wheelchair	___ No	___ Have in the past	___ Yes
f. Hospital Bed	___ No	___ Have in the past	___ Yes
g. Cane	___ No	___ Have in the past	___ Yes
h. Hearing Aid	___ No	___ Have in the past	___ Yes
i. Glasses/Contact Lenses	___ No	___ Have in the past	___ Yes
j. Other Medical Devices:	___ No	___ Have in the past	___ Yes
• Specify Type: _____			

19. Do you have a living will/advanced directive? (Documents that makes your health care wishes known)

___Yes ___No ___Don't remember

Thank you for taking the time to complete.

Please mail back to: 929 Gessner Rd Ste 1500, Houston, TX 77024

Or Email: MHHealthSolutionsCaseMgmt@memorialhermann.org