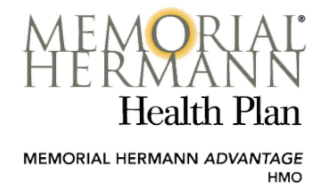
HRA

Name



First

Last

Address

Street Address

Address Line 2

City

State/Region/Province

Postal / Zip Code

Country

Phone

Email

Date of Birth

Gender

☐ Female

☐ Male

Height

Weight

PCP Name

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

In general how would you rate your health?

☐ Good ☐ Fair ☐ Poor

Do you live:

☐ Alone ☐ With Spouse ☐ With other family member ☐ With a non-relative ☐ Nursing home or assisted living facility

Are you on a special diet?

☐ No ☐ Yes

If Yes, please explain

Do you exercise regularly or take part in an exercise program?

☐ No ☐ Yes, Daily ☐ Yes, 3 times a week

Do you smoke?

☐ No ☐ Yes, but I'd like to quit ☐ Yes, but I'm not ready to quit

Do you consume alcohol?

☐ Yes ☐ No

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

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 every day

In the past two weeks have you been feeling downhearted, depressed, or blue?

☐ Not at all ☐ Twice a week ☐ Four times a week ☐ Nearly every day

How often do you get the social and emotional support you need:

☐ Always ☐ Sometimes ☐ Never

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In the past six months, have you experienced leaking of urine?

- ☐ Not at all
- ☐ Sometimes
- ☐ All the time

Have you talked to a doctor or a nurse about bladder leakage?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?

- ☐ Yes
- ☐ No
- ☐ Sometimes

Medications

How many prescriptions do you take per day?

- ☐ 5 or less
- ☐ 6-10
- ☐ 11-29
- ☐ 20+

Do you have problems taking your medications prescribed by your doctor?

- ☐ Yes, all the time
- ☐ Yes, but only sometimes
- ☐ No, not at all

If yes, do you skip taking your medication?

- ☐ Yes
- ☐ No
- ☐ Sometimes

If yes, do you cut your medications in half?

- ☐ Yes
- ☐ No
- ☐ Sometimes

If yes, is the cost a factor?

- ☐ Yes
- ☐ No
- ☐ Sometimes

If yes, are the side effects a factor?

- ☐ Yes
- ☐ No
- ☐ Sometimes

Please explain the reason you experience problems with taking your medications if the reasons above do not apply.

Daily Living Activities

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Eating/Preparing meals

- [ ] No difficulty
- [ ] Some difficulty
- [ ] Unable to do/need help

Walking

- [ ] No difficulty
- [ ] Some difficulty
- [ ] Unable to do/need help

Getting up from a sitting position

- [ ] No difficulty
- [ ] Some difficulty
- [ ] Unable to do/need help

Organizing your day

- [ ] No difficulty
- [ ] Some difficulty
- [ ] Unable to do/need help

Dressing

- [ ] No difficulty
- [ ] Some difficulty
- [ ] Unable to do/need help

Bathing/Toileting

- [ ] No difficulty
- [ ] Some difficulty
- [ ] Unable to do/need help

Driving

- [ ] No difficulty
- [ ] Some difficulty
- [ ] Unable to do/need help

Housekeeping

- [ ] No difficulty
- [ ] Some difficulty
- [ ] Unable to do/need help

Getting in/out of bed

- [ ] No difficulty
- [ ] Some difficulty
- [ ] Unable to do/need help

Preventive Services

Flu vaccine w/in the last 12 months

- [ ] Yes
- [ ] No
- [ ] No, doctor advised against it

Eye Exam w/in the last 12 months

- [ ] Yes
- [ ] No
- [ ] No, doctor advised against it

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Blood in stool test w/in the last 12 months

☐ Yes ☐ No ☐ No, doctor advised against it

Pneumonia Vaccine

☐ Yes ☐ No ☐ No, doctor advised against it

Shingles Vaccine

☐ Yes ☐ No ☐ No, doctor advised against it

Whooping Cough Vaccine

☐ Yes ☐ No ☐ No, doctor advised against it

Colonoscopy w/in the last 10 years

☐ Yes ☐ No

If yes, when and where?

Sigmoidoscopy w/in the last 5 years

☐ Yes ☐ No

If yes, when and where?

Cologuard w/in the last 3 years

☐ Yes ☐ No

Mammogram

☐ Yes ☐ No ☐ No, doctor advised against it ☐ N/A

If N/A, please explain

Medical Conditions

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Asthma

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

Cancer

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

If Yes, specify type

Diabetes

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

Depression/Anxiety

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

Hepatitis

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

Kidney Failure/Disease

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

High Blood Pressure/Hypertension

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

Congestive Heart Failure

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

COPD/Emphysema

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

Stroke

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

Vision issues

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

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Hearing issues

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

High Cholesterol

- [ ] Yes
- [ ] No
- [ ] Yes, in the past but nolonger

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

Oxygen

- [ ] Yes
- [ ] No
- [ ] Have in the past

C-PAP

- [ ] Yes
- [ ] No
- [ ] Have in the past

Nebulizer

- [ ] Yes
- [ ] No
- [ ] Have in the past

Walker

- [ ] Yes
- [ ] No
- [ ] Have in the past

Wheelchair

- [ ] Yes
- [ ] No
- [ ] Have in the past

Hospital Bed

- [ ] Yes
- [ ] No
- [ ] Have in the past

Cane

- [ ] Yes
- [ ] No
- [ ] Have in the past

Hearing aid

- [ ] Yes
- [ ] No
- [ ] Have in the past

Glasses/Contact Lenses

- [ ] Yes
- [ ] No
- [ ] Have in the past

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Other medical devices

Yes No Have in the past

Specify type of other medical device

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

Yes No Don't remember

Would you like for us to schedule your Annual Wellness Visit with your PCP?

Yes No

Thank you for taking the time to complete.
Please mail back to: 929 Gessner Road, Suite 1500, Houston, TX 77024 or email to: MHHealthSolutionsCaseMgmt@memorialhermann.org

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