MEMORIAL HERMANN Health Plan
MEDICARE ADVANTAGE PLANS

Member Name: _____ Today's Date_____

Member Date of Birth _____ Member ID# (found on ID card) _____

Please clearly circle or mark your answers.

1. Would you say that in general, your health is?

- Excellent
- Very Good
- Good
- Fair
- Poor
- No response

2. Do you have one person you think of as your personal doctor or health care provider?

- Yes
- No
- No response

3. Have you completed an advanced directive, medical/financial power of attorney?

- Yes
- No
- No response

4. During the past 12 months, have you had either the flu vaccine that was sprayed in your nose or a flu shot injected into your arm?

- Yes
- No
- No response

5. Have you received the Covid-19 vaccine?

- 1st dose
- 2nd dose
- No
- No response

6. When was the last time you had a colon cancer screening?

- Within the past year (less than 12 months ago)
- Within the past 10 years _when?_____
- Never/Don't know
- No response

7. How long has it been since you had your last mammogram?

- Within the past year (less than 12 months ago)
- Within the past 2 years (1-2 years ago)
- Never/Don't know
- No response

8. Have you ever been told by a doctor, nurse or other health care professional that you have any of the following conditions?

- Diabetes
- Heart Failure
- High Blood Pressure
- COPD/Emphysema/Chronic Bronchitis/Chronic Pneumonia/Chronic Obstructive Asthma
- Asthma
- Kidney Disease/Failure
- Cancer
- Behavioral or Mental Health Conditions
- Hepatitis C
- HIV/AIDS
- Arthritis/Rheumatoid Arthritis/Fibromyalgia/Gout/Lupus
- Other

9. In the past 12 months, have you been to the Emergency Room?

- 1 time
- 2 times
- 3 or more times
- No response

10. In the past 12 months, have you been hospitalized?

- 1 time
- 2 times
- 3 or more times
- No response

11. Has body pain made it difficult to work or complete activities?

- Yes
- No
- No response

12. Do you have any upcoming surgeries?

- Yes
  - What type of surgery and when? _____
- No
- No response

13. How many medications do you take on a daily basis?

- 1-3 Medications
- 4-6 Medications
- 7-10 Medications
- 10 or more Medications
- No response

14. How often do you miss a dose of your medication(s)?

- 1-2 times a week
- 3-4 times a week
- 5 or more times a week
- Never
- No response

15. To your knowledge, do any of your medications require approval by your insurance?

- Yes
- No
- No Response

16. Do you use any of the following special equipment or assistive devices?

- Cane
- Walker
- Wheelchair
- Motorized wheelchair
- Hoyer Lift
- Hospital Bed
- None

17. Are you currently receiving any of the following services?

- Home Health Nurse/Aide
- PT, OT or Speech Therapy
- Social Worker
- Adult Day Care Center
- Other _____
- None

18. Are you blind or do you have difficulty seeing, even when wearing glasses?

- No
- Yes
- Legally Blind
- No response

19. Do you have difficulty hearing? (while using hearing aids, if applicable)

- No
- Yes
- No response

20. Do you have difficulty chewing food (while using dentures, if applicable)
    - No
    - Yes
    - No response
21. In general, how would you describe your nutritional status?
    - Good
    - Fair
    - Poor
    - No response
22. Do you have difficulty with any of the following tasks: toileting, feeding, cooking, dressing, grooming, walking, and bathing/personal hygiene?
    - Yes
    - No
    - No response
23. Do you have difficulty with any of the following tasks: Using the telephone, shopping, preparing meals, managing finances, and housekeeping?
    - Yes
    - No
    - No response
24. What is your living situation today?
    - Alone
    - Spouse
    - Family member
    - Other nonrelative
    - Nursing home/Assisted living
25. What is the highest grade or year of school you completed?
    - Never attended school
    - Grades 1 through 8
    - Grades 9 through 12 - Some high school
    - Graduated high school or GED
    - Some college
    - Graduated college
    - No response
26. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
    - Yes
    - No
    - No response

27. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home? How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is:

    - Yes
    - No
    - Very hard
    - Somewhat hard
    - Not hard at all
    - No response

28. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?

    - Not at all
    - A little bit
    - Somewhat
    - Quite a bit
    - Very much

29. Have you had trouble falling asleep, staying asleep, or sleeping too much?

    - Yes
    - No
    - No response

30. Because of a physical, mental, or emotional condition, do you have difficulty concentrating, remembering, or making decisions?

    - Yes
    - No
    - No response

31. During the past two weeks:

    1. Have you been bothered by having little interest or pleasure in doing things? (PHQ2)

    - Yes
    - No
    - No response

    2. Have you been bothered by feeling down, depressed, or hopeless? (PHQ2)

    - Yes
    - No
    - No response

32. How many times in the past year have you had 5 or more drinks in a day? (Men)

    How many times in the past year have you had 4 or more drinks in a day? (Women)

    (1 drink = a 12 oz. beer or a 5 oz. glass of wine or a 1.5 oz. shot of liquor)

    - None
    - 1 or more
    - No response

33. How many times in the past year have you used a recreational drug or used prescription medication(s) not prescribed by your physician?

    - None
    - 1 or more
    - No response

34. Do you currently smoke cigarettes, vape, or use smokeless tobacco products?

    - Yes
    - No
    - Previously used
    - No response

35. Are you interested in talking to a case manager about ways to improve your health or quality of life?

    - Yes
    - No