health net

One Member Per Form

*Indicates Required Field

General Information

Member First Name

Member Last Name

*Date of Birth (MMDDYYYY)

*Medi-Cal ID

On what date are these questions being answered (MMDDYYYY)

Member Preferred Phone Number

Member Email Address

Global Health

In general, how would you rate your health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Unknown

Do you have a doctor or health care provider? ☐ Yes ☐ No ☐ Unknown

Have you seen your doctor or health care provider in the last 12 months? ☐ Yes ☐ No ☐ Unknown

Do you ever have any problems with transportation to your medical appointments? ☐ Yes ☐ No ☐ Unknown

How many times have you been in the hospital in the last 3 months?

☐ None ☐ One time ☐ Two times ☐ Three or more times ☐ Unknown

How many times have you been in the Emergency Department in the last year?

☐ None ☐ One time ☐ Two times ☐ Three or more times ☐ Unknown

How many medicines are you currently taking that were prescribed by your doctor or health care provider?

☐ 0 ☐ 1-3 ☐ 4-7 ☐ 8-14 ☐ Greater than or equal to 15 ☐ Unknown

What is your height (enter response in feet/inches)?

Feet ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ Unknown

Inches ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ Unknown

What is your weight (enter response in pounds)?

Have you received a flu shot in the last 12 months? ☐ Yes ☐ No ☐ Unknown

Do you have problems with your teeth or mouth that make it hard for you to eat? ☐ Yes ☐ No ☐ Unknown

Do you eat at least 2 meals per day? ☐ Yes ☐ No ☐ Unknown

Do you eat fruits and vegetables every day? ☐ Yes ☐ No ☐ Unknown

Do you participate in any physical activity (such as walking, water aerobics, bowling, etc.) during the week?

☐ Yes ☐ No ☐ I am unable to exercise due to medical conditions ☐ Unknown

Do you always use a seatbelt when you drive or ride in a car? ☐ Yes ☐ No ☐ N/A ☐ Unknown

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Physical Health

Have you ever been told by a doctor or health care provider that you have any of these conditions? (Check all that apply)

- Arthritis
- Asthma
- Cancer
- Chronic Kidney Disease
- COPD/ Emphysema
- Developmental Delay
- Diabetes Type 1
- Diabetes Type 2
- Pre-Diabetes
- Heart Disease
- Heart Failure
- Hepatitis
- High Blood Pressure
- High Cholesterol
- HIV
- Sickle Cell Disease (not trait)
- Stroke
- Transplant

Do you have any other conditions not listed above? Yes No

Are you pregnant? Yes No N/A

Behavioral Health

In general, how satisfied are you with your life?

Very Satisfied Satisfied Dissatisfied Very Dissatisfied Unknown

In the past two weeks have you been bothered by any of the following problems?

Feeling Lonely

Not at all Several Days More than half the days Nearly every day Unknown

Little interest or pleasure in doing things

Not at all Several Days More than half the days Nearly every day Unknown

Feeling down, depressed or hopeless

Not at all Several Days More than half the days Nearly every day Unknown

Over the past month (30 days), how many days have you felt lonely

None - I never feel lonely Less than 5 days More than half the days (more than 15) Most Days - I always feel lonely

Do you feel the stress in your life is affecting your health? Yes No Unknown

What are your plans for managing stress? No changes needed No plan to change

Started making changes Plan to change in the next month Plan to change in next 6 months Unknown

During the past year, how often did you have 5 or more alcoholic drinks in one day?

Never Once or Twice Monthly Weekly Daily or almost daily Unknown

During the past year, how often did you use tobacco products?

Never Once or Twice Monthly Weekly Daily or almost daily Unknown

Have you been diagnosed with a behavioral health disorder like anxiety, depression, bipolar or schizophrenia?

Yes No Unknown

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Behavioral Health Continued

Have you been prescribed anti-psychotic medication within the past 90 days? Yes No Unknown

Activities of Daily and Independent Living

During the last month, have you had pain that interfered with completion of housework or your ability to work outside the home? Yes No Unknown

Do you have a caregiver who helps you on a regular basis? Yes No Unknown

Do you use any assistive devices? Yes No Unknown

Have you used oxygen in the last 90 days? Yes No Unknown

Do you receive any home health services? Yes No Unknown

Do you need help with any of these actions? (Check Yes or No to each action)

Taking a bath or shower	Yes	No	Going Upstairs	Yes	No
Eating	Yes	No	Getting dressed	Yes	No
Brushing Teeth, brushing hair, shaving	Yes	No	Making meals or cooking	Yes	No
Getting out of a bed or chair	Yes	No	Shopping and getting food	Yes	No
Using the toilet	Yes	No	Walking	Yes	No
Washing dishes or clothes	Yes	No	Writing checks or keeping track of money	Yes	No
Getting a ride to the doctor or to see your friends	Yes	No	Doing house or yard work	Yes	No
Going out to visit family or friends	Yes	No	Using the Phone	Yes	No
Keeping track of appointments	Yes	No	If yes, are you getting all the help you need with these actions	Yes	No

**In the past two months have you been living in stable housing that you own, rent or stay in as part of a household? Yes No Unknown

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Activities of Daily and Independent Living Continued

Can you live safely and move easily around in your home? Yes No

If No, does the place where you live have:

Good lighting?	Yes	No	Good heating?	Yes	No
Good cooling?	Yes	No	Rails for any stairs or ramps?	Yes	No
Hot Water?	Yes	No	Indoor Toilet?	Yes	No
A door to the outside that locks?	Yes	No	Stairs to get into your home or stairs inside your home?	Yes	No
Elevator?	Yes	No	Space to use a wheelchair?	Yes	No
Clear ways to exit your home?	Yes	No			

I would like to ask you about how you think you are managing your health conditions

Do you need help taking your medicines?	Yes	No
Do you need help filling out health forms?	Yes	No
Do you need help answering questions during a doctor's visit?	Yes	No
Do you have family members or others willing and able to help you when you need it?	Yes	No
Do you ever think your caregiver has a hard time giving you all the help you need?	Yes	No
Are you afraid of anyone or is anyone hurting you?	Yes	No
Have you had any changes in thinking, remembering, or making decisions?	Yes	No
Have you fallen in the last month?	Yes	No
Are you afraid of falling?	Yes	No
Do you sometimes run out of money to pay for food, rent, bills and medicine?	Yes	No
Is anyone using your money without your ok?	Yes	No
Would you like to work with a nurse or social worker to make a plan for your healthcare?	Yes	No
Would you like to talk with a nurse or social worker and your doctor about a plan to meet your healthcare needs?	Yes	No

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