Today's date: _____

ID #: _____

Name: _____

Address: _____

_____

Cigna HealthSpring®

Please call Customer Service at 1-800-668-3813 (TTY 711) to make address and/or phone number changes.

General questions

1. What is your height?

Feet	❍ A) 3	❍ B) 4	❍ C) 5	❍ D) 6	❍ E) 7						
Inches	❍ A) 0	❍ B) 1	❍ C) 2	❍ D) 3	❍ E) 4	❍ F) 5					
	❍ G) 6	❍ H) 7	❍ I) 8	❍ J) 9	❍ K) 10	❍ L) 11					

2. What is your weight? *(Pounds (lbs))*

3. In general, how would you rate your health?

❍ A) Under 100 ❍ B) 100-125 ❍ C) 126-150 ❍ D) 151-175
❍ E) 176-200 ❍ F) 201-225 ❍ G) Over 226

❍ A) Excellent ❍ B) Very good ❍ C) Good ❍ D) Fair ❍ E) Poor

4. Have you had a flu shot this year or are you planning to receive one this year? ❍ A) Yes ❍ B) No

When was the last time you had a:	*In the last year*	*In the last 2-4 years*	*In the last 5 years*	*In the last 10 years*	*Never*	*Not applicable*
5. Pneumonia vaccine?	❍ A)	❍ B)	❍ C)	❍ D)	❍ E)	❍ F)
6. Breast cancer screening (Mammogram)?	❍ A)	❍ B)	❍ C)	❍ D)	❍ E)	❍ F)
7. Colorectal cancer screening (Colonoscopy)?	❍ A)	❍ B)	❍ C)	❍ D)	❍ E)	❍ F)
8. Cervical cancer screening (PAP Smear)?	❍ A)	❍ B)	❍ C)	❍ D)	❍ E)	❍ F)

9. Do you exercise regularly or take part in a physical exercise program?

❍ A) Yes, daily ❍ B) Yes, more than 3 times a week ❍ C) Yes, fewer than 3 times a week ❍ D) No

Your health

10. What medical conditions do you have or have you had in the past? *(Please indicate all that apply.)*

- ❍ A) Anxiety
- ❍ B) Asthma
- ❍ C) Bi-polar disorder
- ❍ D) Cancer
- ❍ E) COPD/emphysema
- ❍ F) Coronary heart disease
- ❍ G) Dementia
- ❍ H) Depression
- ❍ I) Diabetes
- ❍ J) Hearing problems
- ❍ K) Heart failure
- ❍ L) Hypertension
- ❍ M) Organ transplant
- ❍ N) Renal/kidney failure
- ❍ O) Schizophrenia
- ❍ P) Stroke
- ❍ Q) None
- ❍ R) Vision problems
- ❍ S) Other

11. Which of the following are you currently receiving treatment for? *(Please indicate all that apply.)*

- ❍ A) Anxiety
- ❍ B) Asthma
- ❍ C) Bi-polar disorder
- ❍ D) Cancer
- ❍ E) COPD/emphysema
- ❍ F) Coronary heart disease
- ❍ G) Dementia
- ❍ H) Depression
- ❍ I) Diabetes
- ❍ J) Hearing problems
- ❍ K) Heart failure
- ❍ L) Hypertension
- ❍ M) Organ transplant
- ❍ N) Renal/kidney failure
- ❍ O) Schizophrenia
- ❍ P) Stroke
- ❍ Q) None
- ❍ R) Vision problems
- ❍ S) Other

12. How often do you take medications? ❍ A) Daily ❍ B) Weekly ❍ C) As needed ❍ D) Never

13. How many medications do you take? ❍ A) 0 ❍ B) 1-3 ❍ C) 4-5 ❍ D) 6-7 ❍ E) 8+

14. Do you find that you sometimes have to choose between buying groceries or medications? ❍ A) Yes ❍ B) No

15. Have you fallen in the past 6 months? *(A fall is when your body goes to the ground without being pushed.)* ❍ A) Yes ❍ B) No

16. In the past 3 months, how many times did you go to the Emergency Room?
❍ A) 0 ❍ B) 1 ❍ C) 2 ❍ D) 3 or more

17. In the past 6 months, how many times have you had unplanned overnight stays as a patient in a hospital? ❍ A) 0 ❍ B) 1 ❍ C) 2 ❍ D) 3 or more

18. Has your doctor recently told you that you need to lose weight? ❍ A) Yes ❍ B) No

19. Are you on a special diet recommended by your doctor *(low sodium, low cholesterol, low fat)*? ❍ A) Yes ❍ B) No

20. In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? *(1 serving = 1 cup of*

fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.)

❍ A) 0 ❍ B) 1-2 ❍ C) 3 ❍ D) 4+

21. In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day? *(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)*

❍ A) 0 ❍ B) 1-2 ❍ C) 3-4 ❍ D) 5+

22. In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)

❍ A) 0 ❍ B) 1 ❍ C) 2-3 ❍ D) 4+

23. In the past 7 days, how many sugar-sweetened *(not diet)* beverages did you typically consume each day? ❍ A) 0 ❍ B) 1 ❍ C) 2-3 ❍ D) 4+

24. In the past 2 weeks, have you experienced a change in the amount you normally eat, either poor appetite or overeating? ❍ A) Yes ❍ B) No

25. When was the last time you smoked or used any tobacco products? *(cigarettes, chew, snuff, pipes, cigars, vapor cigarettes)*

❍ A) Today ❍ B) Last week ❍ C) Last month ❍ D) Last 3 months
❍ E) Last year ❍ F) A year to 5 years ago ❍ G) Longer than 5 years ago ❍ H) Never

26. Are you interested in quitting? ❍ A) Yes ❍ B) No ❍ C) Not applicable

27. In the past 2 weeks, have you felt stressed or anxious? ❍ A) Yes ❍ B) No

28. In the past 2 weeks, have you had little interest or pleasure in doing things that you normally like to do? ❍ A) Yes ❍ B) No

29. In the past 2 weeks, have you been feeling downhearted, depressed or “blue” more than usual? ❍ A) Yes ❍ B) No

30. Are you using any street drugs or abusing medications? ❍ A) Yes ❍ B) No

31. Do you drink alcohol? ❍ A) Yes ❍ B) No

32. Have you ever thought you should cut down your drug or alcohol use? ❍ Yes ❍ No ❍ Not Applicable

33. Have you ever felt annoyed when people have commented on your drug or alcohol use? ❍ A) Yes ❍ B) No ❍ C) Not applicable

34. Have you ever felt guilty or badly about your drug or alcohol use? ❍ A) Yes ❍ B) No ❍ C) Not applicable

35. Have you ever used drugs to ease withdrawal symptoms, or to avoid feeling low after using drugs or alcohol? ❍ A) Yes ❍ B) No ❍ C) Not applicable

36. Have you ever been treated for drug or alcohol abuse? ❍ A) Yes ❍ B) No ❍ C) Not applicable

37. In the past 4 weeks, how much body pain have you had?

❍ A) None ❍ B) Mild ❍ C) Very mild ❍ D) Moderate ❍ E) Severe ❍ F) Very severe

38. During the past 4 weeks, how much did pain interfere with your normal activities? ❍ A) Not at all ❍ B) A little bit ❍ C) Moderately ❍ D) Quite a bit ❍ E) Extremely

39. During the past 4 weeks, how has your health impacted your ability to work or caused you to be absent from activities you enjoy? ❍ A) Not at all ❍ B) A little bit ❍ C) Moderately ❍ D) Quite a bit ❍ E) Extremely

Do you need help doing the following?

	Yes	*No*		*Yes*	*No*
40. Standing up from a sitting position?	❍ A)	❍ B)	41. Walking in the house?	❍ A)	❍ B)
42. Walking outside of the house?	❍ A)	❍ B)	43. Preparing a meal?	❍ A)	❍ B)
44. Eating a meal?	❍ A)	❍ B)	45. Getting dressed?	❍ A)	❍ B)
46. Bathing?	❍ A)	❍ B)	47. Using the toilet?	❍ A)	❍ B)
48. Organizing your day?	❍ A)	❍ B)	49. Driving or getting to places?	❍ A)	❍ B)

50. If you answered “Yes” to any of the above questions, do you have someone who can assist you? ❍ A) Yes ❍ B) No

51. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ❍ A) Always ❍ B) Usually ❍ C) Sometimes ❍ D) Never

52. In the past 2 weeks, have you experienced a significant change in the amount you normally sleep, either trouble getting to sleep or sleeping too much? ❍ A) Yes ❍ B) No

Advanced care planning

53. Do you have a Medical Power of Attorney? *(Someone to make medical decisions for you in the event you are unable to)* ❍ A) Yes ❍ B) No ❍ C) Don't know/don't remember

54. Do you have a living will/advance directive? *(Documents that makes your health care wishes known)* ❍ A) Yes ❍ B) No ❍ C) Don't know/don't remember

55. Is a copy of your advance directive on file at your doctor's office? ❍ A) Yes ❍ B) No ❍ C) Don't know/don't remember

About you

My health is important to me.	*Strongly disagree*	*Disagree*	*Agree*	*Strongly Agree*
56. I am ultimately the one responsible for taking care of my health and wellness.	❍ A)	❍ B)	❍ C)	❍ D)
57. It is important for me to take an active role in my health care.	❍ A)	❍ B)	❍ C)	❍ D)
58. I am confident I can prevent or reduce problems associated with my health.	❍ A)	❍ B)	❍ C)	❍ D)
59. I am confident I know when I need to seek medical care and when I am able take care of myself.	❍ A)	❍ B)	❍ C)	❍ D)
60. I am confident I can talk to my doctor about my health concerns even when he or she does not ask.	❍ A)	❍ B)	❍ C)	❍ D)
61. I am confident I can follow through on medical treatments I may need to do at home.	❍ A)	❍ B)	❍ C)	❍ D)

62. Who completed this survey form? ❍ A) Myself ❍ B) Relative of mine ❍ C) Friend of mine ❍ D) Professional caregiver of mine

63. Do you live?

❍ A) Alone ❍ C) With other family member ❍ E) Nursing home or assisted living facility
❍ B) With Spouse ❍ D) With non-relative

64. What is your primary Language? ❍ A) English ❍ B) Spanish ❍ C) Other

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65. What is the highest grade or level of school that you completed?

❍ A) 8th grade or less ❍ B) Some high school, but did not graduate ❍ C) High school graduate or GED
❍ D) Some college or 2 year degree ❍ E) 4 year college graduate ❍ F) More than a 4 year college degree

66. What is your ethnicity?

❍ A) African American ❍ B) Native American ❍ C) Hispanic ❍ D) Native Hawaiian ❍ E) Indian
❍ F) Asian ❍ G) Caucasian ❍ H) Pacific Islander ❍ I) Other

67. Do you ever choose not to seek medical care because of religious or personal beliefs? ❍ A) Yes ❍ B) No ❍ C) Prefer not to answer