# Adult Health Risk Assessment

| Date: | MCC Staff Member: | Date Completed: |
|---|---|---|
| Member Name: | Medicaid ID: | Date of Birth: |

## DEMOGRAPHIC INFORMATION

| Primary Language: | Race/Ethnicity: | Age: |
|---|---|---|
| Sex: Male<br>Female | Date of Enrollment: | |

Address:

| Home Phone#: | Cell Phone #: | Email: |
|---|---|---|

| Other Insurance: | Is there a Legal Guardian or Primary Care Giver?<br>Yes ☐ No ☐ |
|---|---|

**Care Giver/Guardian Name:**

**Address:** **Phone #:**

Receiving out of network treatment? Yes ☐ No ☐

Where do you currently live? (select all that apply)

☐ House/Apartment ☐ Assisted Living ☐ Shelter ☐ Homeless ☐ Supervised

Who do you live with? (select all that apply)

☐ Partner/Spouse ☐ Alone ☐ Roommate ☐ Adult Family ☐ Minor Children

## HEALTHCARE INFORMATION

**Are documents available for:**

- **Prior existing orders** ☐
- **Provider appointments, (e.g., dental appointments, surgeries, etc)** ☐
- **In the past 12 months how many times have you visited a Doctor's office?**
  - Gone to the emergency room — Select
  - Stayed overnight in a hospital — Select

*All sections need to be completed*

**Current Providers:**

**1.) Provider Name:** _____

**Address:** _____ **Phone #:** _____

**Current Providers:**

**2.) Provider Name:** _____

**Address:** _____ **Phone #:** _____

**Current Providers:**

**3.) Provider Name:** _____

**Address:** _____ **Phone #:** _____

**INFORMATION REVIEWED**

Do you use any of the following? If the response of "Never" is selected for each of the four items below, please skip to the next question.

| | Never | Previously | Currently (within the last year) |
|---|---|---|---|
| Cigarettes | ○ | ○ | ◉ |
| Other tobacco | ○ | ○ | ◉ |
| Alcohol | ○ | ○ | ◉ |
| Non-prescribed drugs | ○ | ○ | ◉ |

How long has it been since you last smoked a cigarette, even one or two puffs? *(For those who respond previously to cigarettes question above)* Select

Cigarettes Per Day: *(For those who respond currently or previously to cigarettes question above)*

Select

Years Smoked: *(For those who respond currently or previously to cigarettes question above)*

| Alcohol Drinks Per Week | None | 1- 7 | 8-14 | 15-21 | More than 21 |
|---|---|---|---|---|---|
| | ○ | ○ | ○ | ○ | ○ |

On the days that you do drink, how many drinks do you have?

**1 drink = 1 beer, 1 glass of wine, 1 mixed drink, or 1 shot

## *4. Lab Results*

Date of last results:

| HLD-C | LDL-C | Triglycerides | Total Cholesterol | Blood Sugar | HbA1C |
|---|---|---|---|---|---|
| | | | | | |

### *5. Vitals*

| Date taken: | | | | |
|---|---|---|---|---|
| BP: | Height: | Weight: | BMI: **Calculated and displayed only on HWQ report.** | Waist |

### *6. Social Activity*

| | Yes | No |
|---|---|---|
| I am happy with the friendships I have | ☐ | ☐ |
| I have people with whom I can do enjoyable things | ☐ | ☐ |
| In a crisis, I have the support I need from family or friends | ☐ | ☐ |
| I am able to get transportation to the places I need to go | ☐ | ☐ |

### *7. Physical Activity*

What type of physical activity or exercise did you spend the most time doing during the past month?

| How many times per week did you do this activity in the past month? | 0 | 1-2 | 3-4 | 5+ |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ |

When you took part in this activity, how long were you consistent?

| Less than 10 minutes | 10-20 minutes | 21-30 minutes | 30+ minutes |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

### *8. Depression*

On average how many hours of sleep do you get per night?

Select

During the past two weeks, have you been bothered by feeling down, depressed or

Select

Little interest or pleasure in doing things?

Select

*All sections need to be completed*

| How often do you feel stressed? |
|---|
| Select |

### *9. Nutrition*

| | Never | 0-1 | 2-4 | 5+ |
|---|---|---|---|---|
| How many servings of fruit do you eat in a typical day? | | | | |
| How many servings of vegetables do you eat in a typical day? | | | | |
| How many days per week do you eat fast food *(like hamburgers or pizza)*? | | | | |

### *10. Preventive Test History*

| When was the last time you've had: | | | | |
|---|---|---|---|---|
| | Never | Less Than 1 Year | 1 – 2 Years | 3 – 4 Years |
| Colon cancer screen | ☐ | ☐ | ☐ | ☐ |
| Flu vaccine | ☐ | ☐ | ☐ | ☐ |
| Pneumonia vaccine | ☐ | ☐ | ☐ | ☐ |
| Tetanus vaccine | ☐ | ☐ | ☐ | ☐ |
| Dental exam | ☐ | ☐ | ☐ | ☐ |
| Pap test (women only) | ☐ | ☐ | ☐ | ☐ |
| Mammogram (women only) add date | ☐ | ☐ | ☐ | ☐ |
| Routine Eye Exam | ☐ | ☐ | ☐ | ☐ |
| Blood pressure Check | ☐ | ☐ | ☐ | ☐ |
| Last Blood pressure reading | | | | |
| If you do not know the exact reading, has your doctor ever told you your blood pressure was high or elevated? | | | | |
| Total Cholesterol results | | | | |
| LDL Cholesterol results | | | | |
| HDL Cholesterol results | | | | |
| If you do not know the exact results, has your doctor ever told you your cholesterol was high? | ☐ | | | |
| Cervical Cancer Screening (PAP test) | | | | |
| Rectal or prostate exam | | | | |
| Prostate Cancer Screening (PSA) | | | | |
| Are you currently pregnant?<br>Estimated due date | | | | |

| | Poor | Not Good | Average | Good | Excellent |
|---|---|---|---|---|---|
| Considering your age, how would you rate your overall health? | ☐ | ☐ | ☐ | ☐ | ☐ |

## *11. Chronic Condition History*

| PHYSICAL EXAM | | | | | |
|---|---|---|---|---|---|
| Head | | Heart | | Extremities | |
| Eyes | | Lungs | | Scrotum | |
| Ears | | Breasts | | Penis | |
| Nose | | Abdomen | | Hernia | |
| Throat | | Vulva | | Prostate | |
| Thyroid | | Vagina | | Rectal | |
| Nodes | | Cervix | | | |
| Carotids | | Uterus | | | |
| Skin | | Adnexae | | | |

Have you ever been told by a doctor or other health professional that you have the following conditions:

| Conditions | Yes | No | Currently Under Medical Care |
|---|---|---|---|
| Allergies | ☐ | ☐ | ☐ |
| Anemia | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ |
| Anxiety | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Back Pain | ☐ | ☐ | ☐ |
| Bronchitis/COPD | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ |
| Chronic pain | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ |
| Heart Problems | ☐ | ☐ | ☐ |
| Heart Failure/CHF | ☐ | ☐ | ☐ |
| Heartburn | ☐ | ☐ | ☐ |
| Hepatitis/Liver Disease | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ |
| HIV/AIDS | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ |
| Liver Disease | ☐ | ☐ | ☐ |
| Migraine headaches | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| Traumatic brain Injury | ☐ | ☐ | ☐ |
| Other: | ☐ | ☐ | ☐ |

If you checked any box above, please look at the list below and check yes if any of these diseases are **currently** present and you are currently managing the condition or have referred the member to a specialist to manage the condition. Please code these diagnoses to the highest level of specificity on the HCFA.

*All sections need to be completed*

| Conditions | Yes | No | Currently Under Medical Care |
|---|---|---|---|
| Bipolar Disorder | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Cancer | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Chemotherapy | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Chronic Kidney Disease | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| CNS Disorders | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| COPD | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Cystic Fibrosis | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Hepatitis C | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| HIV | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Leucopenia | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Leukemia | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Major Depressive Disorder | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Myeloma | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |

*All sections need to be completed*

| | | | |
|---|---|---|---|
| Neutropenia | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| (Any) Osteomy | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Pressure Ulcer | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Quadraplegia | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Radiotherapy | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Schizophrenia | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| Transplants | Yes ☐ | No ☐ | Currently Under Medical Care ☐ |
| **Provider Name:** **Address:** | | **Phone #:** | **Email:** |

*All sections need to be completed*