General Health Risk Screening

We need to know your health history! Please help us by completing this confidential form.
It will help us find out if there is extra care or support we can give you.

If you have any special needs at this time—physical, social or mental—please let us know!
Call Member Services at 1-866-595-8133 (Hearing Loss: 711) Monday through Friday from 7:00 a.m. to 7:00 p.m.

One Member per form

Member Last Name, First:

Date of Birth (MM/DD/YYYY):

***Medicaid ID:**

Name of person answering questions:

Relationship to member:

☐ Parent ☐ Guardian ☐ Spouse ☐ Friend ☐ Lawyer ☐ Provider ☐ Other

If we would need to return a call to you, what is the best time to reach you?

☐ Morning ☐ Afternoon ☐ Evening

What is the best telephone number to reach you?

Member's Height: Feet Inches **Member's Weight:** Pounds

Do you know who your PCP (doctor) is? ☐ Yes ☐ No

Do you have an appointment scheduled with your PCP? ☐ Yes ☐ No

Are you having a problem with any of your medications that prevent you from using them the way your doctor ordered them? ☐ Yes ☐ No

Have you been admitted to a hospital in the last 12 months? ☐ Yes ☐ No

Have you been to the emergency room (ER) more than once in the last six months? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure ☐ N/A

Do you currently have any of the following conditions? (check all that apply)

☐ Alcohol or Substance Abuse ☐ Asthma ☐ Cancer ☐ COPD

☐ Depression ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure

☐ HIV/AIDS ☐ Kidney Disease ☐ Mental Health Condition

☐ Transplant (On waiting list or received transplant in the last 12 months) ☐ Tobacco use

Other medical condition(s)

Do you have any special needs (such as hearing, vision or mobility problems)? ☐ Yes ☐ No

If yes, please describe special needs