Health Information Form

ONE FORM PER MEMBER - **AGES 18 AND OLDER**

Tell us about your health history. *This form will help us find out if there are any extra services or tools you may need.*

Member First Name: _____ Member Last Name: _____

Medicaid ID#: _____ Date of Birth (mm/dd/year): _____

1. Do you feel your health is: ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor ☐ Prefer not to say
2. Have you seen a Primary Care Provider (PCP) (e.g., a doctor, nurse or clinic that you see for check-ups and routine care) in the last 12 months: ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
3. Do you have a specialist(s), for example an allergy doctor or a heart doctor, that you see on an ongoing basis? ☐ Yes ☐ No ☐ Prefer not to say
4. Over the past two weeks, how often have you been bothered by having little interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Prefer not to say
5. Over the past two weeks, how often have you been bothered by feeling down, depressed or hopeless? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Prefer not to say
6. How many emergency room (ER) visits in the past six months? ☐ 0 visits ☐ 1-2 visits ☐ 3-4 visits ☐ 5 or more visits ☐ Prefer not to say
7. How many unplanned hospitalizations in the last 12 months? ☐ 0 visits ☐ 1-2 visits ☐ 3-4 visits ☐ 5 or more visits ☐ Prefer not to say
8. Have you seen a dentist in the last 12 months? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
9. Have you had a flu shot in the last 12 months? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
10. Are you up-to-date on your immunizations? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
11. Have you had an eye exam in the last 12 months? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
12. For childbearing females: Are you pregnant or do you suspect that you are pregnant? (Age 55 and under.) ☐ Yes ☐ No ☐ N/A ☐ Prefer not to say
13. Do you have any physical or behavioral health conditions where you are or were told that you should be under the care of a doctor? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
14. Do you have two or more chronic conditions, such as heart disease, arthritis, diabetes, asthma, dementia, bipolar disorder, schizophrenia? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
15. In the last seven days, how would you rate your pain on a scale of 0-10 with zero being no pain to 10 being excruciating pain? ☐ 0-3 pain rating ☐ 4-6 pain rating ☐ 7-8 pain rating ☐ 9 pain rating ☐ 10 pain rating ☐ Prefer not to say
16. Do you take four or more prescription medications on a regular basis? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
17. Do you take your medications as prescribed & instructed by your doctor? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say ☐ N/A
18. Do you have any concerns about your medicines? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say ☐ N/A
19. Do you use any medical equipment currently? (excluding cane, walker, crutches, nebulizer, diabetic supplies) ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
20. Do you need help with activities of daily living? (e.g., bathing, medication, eating) ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
21. What is your current weight? lbs.
22. What is your current height? feet inches
23. In the past 12 months, have you ever thought about harming yourself or others? ☐ Yes ☐ No ☐ Prefer not to say
24. Do you currently use tobacco or electronic cigarettes or vaping products? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
25. Have you used smokeless tobacco products in the last 30 days? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
26. How often do you have (six for women/eight for men) or more drinks in a single occasion? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐ Prefer not to say
27. Do you regularly wear a seatbelt? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

(Continue on reverse side.)

28. In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your heart rate and breathing rate? (This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that may be part of your job).
☐ 5-7 ☐ 3-4 ☐ 1-2 ☐ 0 ☐ Prefer not to say

29. In the past 12 months have you used recreational drugs?
☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

30. Have you had a well woman/well man exam in the past 12 months? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

31. Because difficult relationships can cause health problems, we are asking all of our members the following question: Does a partner or anyone at home hurt, hit or threaten you? ☐ Yes ☐ No ☐ Prefer not to say

32. Do you have a regular, safe place where you sleep and store your things? ☐ Yes ☐ No ☐ Prefer not to say

33. What is your employment status? ☐ Employed
☐ Unemployed, actively seeking employment
☐ Unemployed, not seeking employment
☐ Unemployed/retired, but may want to seek employment
☐ Retired ☐ Prefer not to say

34. Do you have a Social Security disability determination?
☐ Yes ☐ No ☐ Prefer not to say

35. Do you have any current legal problems, or are you currently on probation or parole? ☐ Yes ☐ No
☐ Unsure ☐ Prefer not to say ☐ N/A

36. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? ☐ Never
☐ Sometimes ☐ Usually ☐ Always ☐ Prefer not to say

37. Are you currently receiving supports for healthy eating? (Supplemental Nutrition Assistance Program (SNAP), Food Stamps, Special Supplemental Food Program for Women, Infants and Children (WIC), etc.)? ☐ No ☐ Yes
☐ No, but would like to ☐ Don't know
☐ Prefer not to say

38. What is your highest level of education?
☐ Some high school ☐ High school diploma
☐ Trade school ☐ Some college ☐ College degree
☐ More than a college degree ☐ Prefer not to say

39. Within the past 30 days, where have you been living? (May select more than one.) ☐ Owned or rented home
☐ Stayed at someone else's home ☐ Homeless
☐ Group home setting ☐ Hotel
☐ Transitional living facility or temporary emergency shelter
☐ Other ☐ Prefer not to say

40. How many addresses did you have in the past 12 months? _____ ☐ Prefer not to say

41. If employed, do you feel that you are employed adequately based on your skills and knowledge?
☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say ☐ N/A

42. Do you worry about paying bills?
☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say ☐ N/A

43. Would you like to learn more about available financial assistance programs?
☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say ☐ N/A

If you are currently having any problems (physical, social, behavioral) that you would like to talk to a Sunflower staff person about, please call us toll free at 1-877-644-4623 (TTY 711).

Sunflower will use the information on this form to help you get healthcare services. Your information will be kept private and confidential as required by state and federal law. For more information, please see the Notice of Privacy Practice section of your member handbook or call us at 1-877-644-4623 or TTY 711.

Please send this completed form back to Sunflower. You can:

- Use the prepaid envelope (if provided).
- Mail to Medical Management Notifications, PO Box 2010, Farmington MO 63640-9706.
- Fax (toll free) to 1-855-581-2246.
- Email to SunflowerPHCM@sunflowerhealthplan.com.