



**METROPLUSHEALTH
MEMBER ANNUAL
HEALTH ASSESSMENT
FORM |
TELL US HOW
YOU'RE DOING.**



**PLEASE COMPLETE IN FULL AND MAIL BACK TO US AT:
MetroPlus Health Plan • 50 Water Street, 7th Floor • New York, NY 10004**

First, Last Name: _____ **Member ID#:** _____

Mailing Address: _____

Phone: _____ **Date of Birth:** _____ **Height:** ____ ft. ____ in. **Weight:** ____ lbs.

Preferred Language: English Spanish Chinese Creole Urdu Bengali Other: _____

Race: White American Indian Alaskan Native Asian Black / African American
 Native Hawaiian / Pacific Islander Two or More Races Other: _____ Decline to answer

Ethnicity: Hispanic or Latino Non Hispanic or Latino Decline to answer

In general, would you say that your health is: Excellent Good Fair Poor

Would you like us to call you to help you with any urgent health problem? Yes No

Do you have a doctor you see regularly? Yes No

If Yes, has your doctor advised you to start, increase, or maintain some level of exercise or physical activity? (for example, start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program)? Yes No

Do you have any of the following? Diabetes Heart problems High blood pressure Cancer
 Breathing problems (asthma or COPD) Memory problems Hearing problems Vision problems
 Mental / emotional problems Urinary Incontinence HIV Drug or alcohol problems
 Other medical problems: _____

How many different medicines do you take a day? None 1-3 4-7 8 or more

Do you need help with your basic activities (such as getting dressed, taking a bath, eating, getting in / out of a chair)? I'm able to do this without help I need help, and get the help I need
 I need help, and do not get the help I need

Do you need help with housekeeping, taking medication, shopping, money management, preparing meals, or transportation? I'm able to do this without help

I need help, and get the help I need I need help, and do not get the help I need

In the past 6 months, have you ever had to go without healthcare because you didn't have a way to get there? Yes No

Did you fall in the past 6 months? Yes No

Does anyone in your life hurt, threaten, frighten you, or make you feel unsafe?

Yes No Prefer not to answer

Do you use any of the following:

Cane Walker Wheelchair Hospital bed Oxygen Protective Briefs / Pads (Adult diapers)

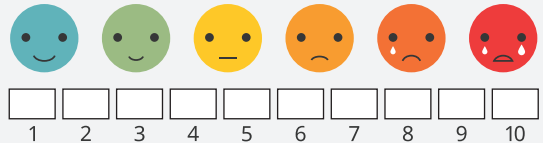
Other _____

Do you have repeated or ongoing pain?

Yes No **If yes, start date:** _____

If yes, where is the pain? _____

If yes, mark off your level of pain here:



What is your living situation?

I have a steady place to live I have a place to live today, but I am worried about losing it in the future

I do not have a steady place to live (temporarily staying with others, in a hotel, shelter, living outside on street, on a beach, in a car, abandoned building, bus or train station, park, other)

Are you worried that the place you are living now is making you sick? (i.e. mold, bugs / rodents, water leaks, not enough heat, other) Yes No Other: _____

Do you currently receive public assistance (Food Stamps, Meals on Wheels, HEAP, EPIC, public or cash assistance, etc.)? Yes No I do not know

In the past year, did you worry that your food could run out before you got money to buy more?

Yes No Prefer not to answer

In the past year, has the electric, gas, oil, or water company threatened to shut off services to your home?

Yes No I do not know

Do you smoke cigarettes, vape (e-cigarettes), or use tobacco? Current Former Never

Did you get the Influenza Vaccine (Flu Shot) this year? Yes No I do not know

Please list your medications (list additional medications of an extra sheet, if applicable):

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication List (continued - list additional medications of an extra sheet, if applicable):

Medication Name: _____ Dose: _____ Frequency: _____
Medication Name: _____ Dose: _____ Frequency: _____
Medication Name: _____ Dose: _____ Frequency: _____
Medication Name: _____ Dose: _____ Frequency: _____



Over the past 2 weeks, how often have you had little interest or pleasure in doing things?

- Not at all Several Days
 More than half of those days Almost every day

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

- Not at all Several Days
 More than half of those days Almost every day

ONLY WOMEN 50 YEARS OLD AND UNDER: Are you pregnant? Yes No I do not know

ONLY WOMEN 50-74 YEARS OLD: Did you have a mammogram (to check for breast cancer) this year or last? Yes No I do not know

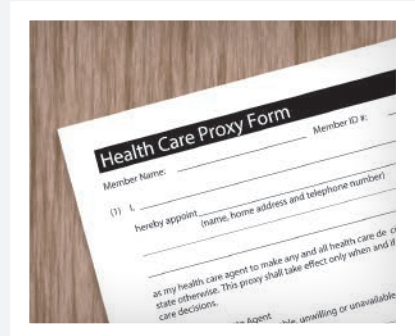
ONLY THOSE 50-75 YEARS OLD: Did you have the following tests to check for colon cancer?

- Colonoscopy (in the past 10 yrs.) Sigmoidoscopy (in the past 5 yrs.)
 Stool Test for blood (within the last yr.)

Do you have any of the following?

- Advance Directive / Living Will (a document that says what medical treatment you would like if you are unable to speak for yourself)
 Health Care Proxy (a person who can make health care decisions for you, if you are not able to)
 No, but advanced care planning was discussed with me
 No, and advanced care planning was not discussed with me
 No, but I am interested to learn more: Yes* No

* We will send you an Advance Directive and Health Care Proxy Form



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