Health risk assessment

Devoted HEALTH PLANS

PROVIDE YOUR PERSONAL INFORMATION

Full name:			**Today's date** (mm/dd/yyyy)**:**
Member ID: **D**	**Birth date** (mm/dd/yyyy)**:**	**Current weight:** lb	**Current height:** ft in

TELL US ABOUT YOUR OVERALL HEALTH AND HEALTH CONDITIONS

Do you have diabetes? ☐ **Yes** ☐ **No**

If yes: Do you have any complications with your diabetes, such as problems with your eyes, nerves (like numbness), or kidneys (like dialysis)? ☐ **Yes** ☐ **No** ☐ **N/A**

Do you have cardiovascular disease? ☐ **Yes** ☐ **No**

Have you gotten care in the emergency room or hospital in the last 12 months? ☐ **Yes** ☐ **No**

Have you fallen in the last 12 months? ☐ **Yes** ☐ **No**

Do you smoke now or have you in the past? ☐ **Yes** ☐ **No**

TELL US ABOUT YOUR MOST RECENT PREVENTIVE CARE

Have you gotten a flu vaccine in the last 12 months? ☐ **Yes** ☐ **No**

Have you gotten the pneumonia shot? ☐ **Yes** ☐ **No**

Have you had a colorectal cancer screening? ☐ **Yes** ☐ **No**

TELL US ABOUT YOUR OVERALL WELL-BEING

In general, would you say your quality of life is:

☐ **Excellent** ☐ **Very good** ☐ **Good** ☐ **Fair** ☐ **Poor**

TELL US ABOUT YOUR OVERALL WELL-BEING

Do you exercise regularly? ☐ Yes ☐ No

Do you regularly have 2 or more alcoholic drinks per day? ☐ Yes ☐ No

Do you regularly feel anxious or depressed? ☐ Yes ☐ No

Choose a number from 0 to 10 that best describes your pain, where 0 is no pain and 10 is the worst pain you could imagine. In the past 7 days, how would you rate your pain on average?

0	1	2	3	4	5	6	7	8	9	10
No pain										Worst imaginable pain

Are you worried that in the next 2 months, you may not have stable housing?[1] ☐ Yes ☐ No

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?[1] ☐ Yes ☐ No

In the last 12 months, did you ever have to go without health care because you didn't have a way to get there?[1] ☐ Yes ☐ No

TELL US ABOUT YOUR CARE AT HOME

Are you confident that you can manage your own care at home, like organizing your medications or setting up doctor visits? ☐ Yes ☐ No

Do you regularly get help from a family member or friend with your medications or medical care? ☐ Yes ☐ No

Do you need help with any of these activities?

- **Getting in and out of bed?** ☐ Yes ☐ No
- **Eating food?** ☐ Yes ☐ No
- **Getting dressed?** ☐ Yes ☐ No
- **Bathing?** ☐ Yes ☐ No
- **Using the restroom?** ☐ Yes ☐ No

Want to give us permission to talk about your care with someone you trust, like a spouse or caregiver? Text SHARE to 86685 or visit my.devoted.com/share.

[1]HealthLeads 2018 Social Needs Screening Toolkit, https://healthleadsusa.org/communications-center/resources/the-health-leads-screening-toolkit

Devoted Health is an HMO and/or PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.