4950 SW 8th St.
Coral Gables, FL. 33134
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Health Risk Assessment- Short Form
MARKETPLACE / EXCHANGE MEMBER

Dear Member   Member Service Rep Name: ________________

This Health Risk Assessment Form will help us learn more about you and your health condition in order to plan your health services; to help bring out good health outcomes; and to help you better understand your healthcare needs. Please fill out this form as soon as you can and mail it back to us. If you have any questions, please call your Case Coordinator at (305) 648-4004.

Member Name: ___________________________ Date Completed _______________ Completed By: □ Member □ Family
Phone Number:___________________________
Member ID#:______________________________ DOB___________________________ Primary Language___________________

1. Have you ever been treated for the following (check all that apply):
   - □ Asthma
   - □ Congestive Heart Failure
   - □ Diabetes Mellitus (Blood Sugar)
   - □ Coronary Artery Disease
   - □ Hypertension (High Blood Pressure)
   - □ HIV
   - □ Cancer
   - □ Other
   - □ Any Disability: Hearing, Speech, or any other disability
2. Have you been hospitalized in the past 6 months?
   □ Yes □ No
   If yes, (Name of the facility) (How many times) ____
3. Have you been to the emergency room in the past year?
   □ Yes (how many times)____ □ No
4. What medical equipment do you have at home?
   - □ Cane/Walker
   - □ Wheelchair (Manual or electric)
   - □ Hospital Bed
   - □ Bedside commode
   - □ Oxygen
   - □ Nebulizer
   - □ Other ____________
5. Do you smoke or have you ever smoked?
   □ Yes □ No
   If Yes, what is the date you quit smoking? _____________________________
6. How many prescriptions/medicines do you take each day?
   □ 0 daily medications □ 1 to 3 per day □ 4 to 7 per day □ 8 or more per day
7. Do you feel sad or blue sometimes?
   □ Yes □ No
8. In general, how would you rate your health?
   □ Excellent □ Very good □ Good □ Fair □ Poor
9. When was your last vaccination (or your CHCU) completed ?
   Date: ___________ Provider name and Ph.#____
10. Are you willing to participate in the Disease Management program?
    □ Yes □ No
11. Are you receiving care from another doctor?
    □ Yes □ No If Yes, Doctor: _________________________ Phone Number: __________________
12. Do you have any upcoming surgery or procedure planned:

    Date: __________________ Doctor: _____________________________ Doctor's Phone#:_________________________