Humana

CareSource

Humana – CareSource™ Health Assessment

Humana – CareSource is dedicated to helping you stay as healthy as you can be. Take a moment to answer these questions. You can find out what areas of your health you need to focus on to become a healthier you! You can also fill this out online at the Humana – CareSource website at www.caresource.com/KY

Your answers to these questions will not change your medical plan in any way.

Please tell us about you

Your name _____

Your address _____

Your phone number _____

Your member ID number _____

What is your age? _____

Are you: ❑ Male ❑ Female

Do you have trouble speaking or reading English? ❑ Yes ❑ No

*Si usted prefiere esta informacion en Espanol, favor de llamar a Humana – CareSource al **1-855-852-7005** (TTY: 1-800-648-6056 or 711)*

Do you have any other health plans? ❑ Yes ❑ No

If yes, what is the name of your other plan? _____

Please tell us about your Doctor

Do you have a doctor that you see regularly?

❑ Yes ❑ No ❑ I need help finding a doctor

If you have a doctor:

What is your doctor's name? _____

What is your doctor's address? _____

_____

What is your doctor's phone number? _____

Are you able to get an office visit with your doctor when you need it?

❑ Yes ❑ No ❑ I do not have a doctor

How would you say your health is?

❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor

Activities

In the past 7 days, I exercised _____ days for _____ minutes each day.

How hard do you exercise?

❑ I don't exercise
❑ Light (*like stretching or a walk*)
❑ Moderate (*like a brisk walk*)
❑ Heavy (*like jogging or swimming*)
❑ Very heavy (*like running or stair climbing*)

Do you plan to exercise more?

❑ I am working on that now
❑ I plan to be more active within the next few months
❑ I am not planning any changes

Have you had to cut back or stopped doing things that you like to because of a physical problem or pain?

❑ Yes ❑ No

In the past 7 days did you need any help with?

❑ Eating
❑ Getting dressed or grooming
❑ Walking
❑ Using the toilet
❑ Banking or shopping
❑ Transportation
❑ Preparing food
❑ Using the telephone
❑ Taking your medications

In the past year, how many sick days have you taken off from work?

❑ None ❑ 1 to 3 ❑ 4 to 5 ❑ 5 to 8 ❑ 9 or more

If you have missed work or school was it?

❑ Mostly due to an illness like the flu
❑ Diabetes or Asthma
❑ Needing to care for a loved one
❑ Feelings of stress or feeling anxious
❑ Other

Tobacco Use

In the last 30 days, have you used tobacco?

Smoked: ❑ Yes ❑ No

Used a smokeless tobacco product? ❑ Yes ❑ No

Do you want to quit tobacco use within the next month? ❑ Yes ❑ No

Alcohol Use

(One drink equals one beer, a glass of wine, or a shot of liquor or a mixed drink)

How many drinks have you had in the last 7 days? _____

On days when you have had a drink, how often did you have 4 or more drinks? ❑ Never ❑ Once during the week
❑ 2 to 3 times during the week ❑ More than 3 times during the week

Do you plan on decreasing your alcohol use?
❑ I am working on doing that now ❑ I plan to do this within the next few months
❑ I am not planning on making any changes

Other Substances

Have you used drugs other than those your doctor ordered for you?
❑ Yes ❑ No

Have you ever abused drugs that your doctor has ordered?
❑ Yes ❑ No

Do you plan on decreasing your substance use?
❑ I am working on doing that now ❑ I plan to do this within the next few months
❑ I am not planning on making any changes

Eating Habits

In the past 7 days, how many servings of fruits and vegetables did you eat each day? _____ Servings per day *(Example fruits and vegetables: 1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit.)*

In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day?_____ Servings per day *(Examples of high fiber or whole grain foods: 1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)*

In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? _____ Servings per day *(Examples of fried or high fat foods: fried chicken, fried fish, bacon, french fries, potato chips, doughnuts, whole milk, cream, cheese, or mayonnaise.)*

How many sugar-sweetened (not diet) beverages have you drank in the last 7 days? _____

Are you planning on making healthy changes to your diet?
❑ I am working on doing that now
❑ I plan to do this within the next few months
❑ I am not planning on making any changes

Do you take nutritional supplements like Ensure? ❑ Yes ❑ No

Safety

Do you wear your seat belt when you are in a car?

❑ Yes ❑ No

Do you ever text or email while driving?

❑ Yes ❑ No

How often in the last month did you drive after drinking alcohol?

❑ None
❑ 1 to 3
❑ 4 to 5
❑ 5 to 8
❑ 9 or more

Mood

In the past 2 weeks, how often have you felt down, sad, hopeless, or had little interest in doing things?

❑ Almost all of the time ❑ Some of the time
❑ Most of the time ❑ Almost never

In the past 2 weeks, how often have you felt nervous or anxious?

❑ Almost all of the time ❑ Some of the time
❑ Most of the time ❑ Almost never

In the past 2 weeks, how often were you unable to control these feelings?

❑ Almost all of the time ❑ Some of the time
❑ Most of the time ❑ Almost never

How often have these feelings caused you to stop doing the things that you like to do?

❑ Almost all of the time ❑ Some of the time
❑ Most of the time ❑ Almost never

Do you feel like you have all the emotional support you need?

❑ Yes ❑ No

Learning

How often do you have problems with learning new things?

❑ Almost all of the time ❑ Some of the time
❑ Most of the time ❑ Almost never

How often do you have problems paying attention at school or work?

❑ Almost all of the time ❑ Some of the time
❑ Most of the time ❑ Almost never

How often do you have trouble remembering things?

❑ Almost all of the time ❑ Some of the time
❑ Most of the time ❑ Almost never

If you have missed work or school was it?

❑ Mostly due to an illness like the flu ❑ Needing to care for a loved one
❑ Diabetes or Asthma ❑ Feelings of stress or feeling anxious
❑ Other

Hearing and Vision

Do you have a hard time hearing? ❑ Yes ❑ No

Do you wear hearing aids? ❑ Yes ❑ No ❑ No, but may need them

Do you have problems with seeing or reading and it is not better when wearing glasses or contacts?

❑ Yes ❑ No ❑ I think I need glasses or contacts

Blood Pressure

If your blood pressure was checked by your doctor within the past year, what was it when it was last checked?

❑ Low or normal (at or below 120/80) ❑ High (140/90 or higher)
❑ Borderline high (120/80 to 139/89) ❑ Don't know/not sure

Are you taking medicine to treat high blood pressure?

❑ Yes ❑ No

Cholesterol

If your cholesterol was checked by your doctor within the past year, what was your total cholesterol when it was last checked?

❑ Desirable (below 200) ❑ High (240 or higher)
❑ Borderline high (200–239) ❑ Don't know/not sure

Are you taking medicine to treat high cholesterol?

❑ Yes ❑ No

Blood Glucose (Blood sugar)

If your blood sugar was checked in the past year, what was your fasting blood sugar level the last time it was checked?

❑ Desirable (below 100)
❑ Borderline high (100–125)
❑ High (126 or higher)
❑ Don't know/not sure

If diabetic, and if you have had your hemoglobin A1C level checked in the past year, what was it the last time you had it checked?

❑ Desirable (6 or lower)
❑ Borderline high (7)
❑ High (8 or higher)
❑ Don't know/not sure

Are you taking medicine to treat diabetes?

❑ Yes ❑ No

Overweight/Obesity

What is your height without shoes? *(For example, 5 feet and 6 inches = 5'6")*

Feet _____ Inches _____

What is your weight?

Weight in pounds _____

For Women

Have you had any of these important health screenings?

❑ Mammogram within the past year
❑ A breast exam performed by a health care provider within the last 3 years
❑ A Pap test within the last three years

Are you currently pregnant?

❑ Yes ❑ No

For Men

Have you had any of these important health screenings?

❑ A digital rectal exam within the past year
❑ A PSA (Prostate-Specific Antigen test) within 2 years

Do you perform a testicular self-exam at least once per month?

❑ Yes ❑ No

For Men and Women over Age 50

Have you had any of these important tests to check for colon cancer?

❑ A sigmoidoscopy within the past 5 years
❑ A barium enema within the past 5 years
❑ A colonoscopy within the past 10 years

Your Health

Do you have a history of any of the following conditions?

- ❑ Alzheimer's
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bed Sores
- ❑ Bipolar
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Lung Disease
- ❑ HIV / AIDS
- ❑ Leukemia
- ❑ Mental Disorders
- ❑ Multiple Sclerosis (MS)
- ❑ Muscular Dystrophy
- ❑ Chronic Obstructive Pulmonary (COPD)
- ❑ Congestive Heart Failure (CHF)
- ❑ Amputation (Limb)
- ❑ Chronic Kidney Disease
- ❑ Chronic Pain
- ❑ Chronic Renal Failure
- ❑ Dementia
- ❑ Depression
- ❑ Osteoporosis
- ❑ Paralysis
- ❑ Post-Traumatic Brain Injury
- ❑ Sarcoidosis
- ❑ Schizophrenia
- ❑ Sickle Cell
- ❑ Stomach Problems (ulcers)
- ❑ Stroke
- ❑ Trauma
- ❑ Under Weight
- ❑ Wounds that won't heal
- ❑ Allergies
- ❑ Coronary Artery Disease

Please list any other health conditions that bother you and are not listed:

_____

Have you been in the hospital in the last 6 months?

❑ Yes, I was in the hospital for a condition listed above
❑ Yes, I was in the hospital for a different reason
❑ No, I have not been in the hospital in the last 6 months

Do you have any chronic mental health issues (mental health diagnoses that you have had for longer than three months or those that go away and come back over time)? ❑ Yes ❑ No

How many times have you gone to the emergency room in the last 6 months? ❑ 0 ❑ 1 to 3 ❑ 4 or more

Have you had nursing care in your home in the past 4 months?

❑ Yes ❑ No

Do you have Living Will? ❑ Yes ❑ No

Do you use any medical equipment?

❑ Wheelchair ❑ Walker ❑ Cane ❑ Blood sugar monitor
❑ Blood pressure monitor ❑ Oxygen ❑ Other

Are you currently getting help from any community resources? (Meals on Wheels, church, food pantry)? ❑ Yes ❑ No

Which places have you used to get resource help? _____

_____

Your Health *continued on next page* ➜

Your Health continued from previous page

Are you getting any of these services?

❑ Transportation ❑ Getting food
❑ Your heating or cooling bill ❑ Medical supplies ❑ Other

Do you need help from any of these services?

❑ Transportation ❑ Getting food
❑ Your heating or cooling bill ❑ Medical supplies ❑ Other

Are your flu and/or pneumonia vaccines up to date?

❑ Yes ❑ No

Your Family's Health

Mark the boxes showing immunizations you and your family members have had:

	You	Spouse	Child 1	Child 2	Child 3	Child 4
Chicken Pox						
Diphtheria						
Hepatitis A						
Hepatitis B						
Hib						
HPV						
Influenza						
Measles, Mumps, Rubella						
Meningococcal						
Pneumonia						
Pneumococcal						
Polio						
Rotavirus						
Shingles						

Need Help with This Form?

Please call Humana – CareSource Member Services at **1-855-852-7005** (TTY: 1-800-648-6056 or 711) if you have questions or need help with this form.

Humana – CareSource will use your answers to help identify ways to keep you healthy. We may call to discuss all the ways that Humana – CareSource can help. By Law, we must make sure that your Protected Health Information is kept private, give you notice of our legal duties and privacy practices; and follow the terms of the notice that are currently in effect. We will share Protected Health Information about you when required to do so by Federal, State or local law. Your Protected Health Information is never sold or shared with anyone unless we are required to do so by Federal, State, or local law.