HEALTH RISK ASSESSMENT FORM

Dear Member,

Answering the questions below helps us to find ways to help you continue to feel good and improve your health. **If you have completed this with an agent, you do not need to complete it again**. Otherwise, please complete and return by e-mail at AstivaUMDept@astivahealth.com, or fax at (714) 908-8055, or mail:
UM Dept. HRA
765 The City Dr. Suite 200
Orange, CA 92868

Date	Name First	Last Name	DOB	Male ❑ Female❑

Contact Preferences

What language do you prefer to speak?

❑ English ❑Vietnamese ❑ Spanish ❑ Korean ❑ Mandarin ❑ Cantonese

❑ Taiwanese ❑ Other_____

What is your email address? _____

Do you use a smart phone or tablet? ❑ Yes ❑ No

Current Health Conditions (*Please mark each condition that applies to you.*)

1. What health conditions do you currently have?

❑ Asthma
❑ COPD
❑ Other breathing or lung conditions
❑ Heart disease
❑ Heart failure
❑ High blood pressure
❑ Kidney disease or kidney failure
❑ Diabetes or high blood sugar
❑ Cancer
❑ HIV or AIDS
❑ Behavioral or mental health conditions
❑ Alzheimer's Disease or other dementia
❑ Other

General Health Topics

2. Have you had your flu shot within the past year? ❑ Yes ❑ No

3. Have you had a COVID vaccine within the past year? ❑ Yes ❑ No

4. When did you last have a pneumonia vaccine?

❑ In the last year ❑ Past 2-4 years ❑ Past 5 years

❑ Last 10 years ❑ Never

5. When did you last have a Tdap (Tetanus, diphtheria, pertussis) vaccine?

❑ In the last year ❑ Past 2-4 years ❑ Past 5 years ❑ Last 10 years ❑ Never

6. Have you had a Shingles (RSV, Shingrix) vaccine? ❑ Yes ❑ No

7. Have you had a colonoscopy within the last 10 years? ❑ Yes ❑ No

8. Have you had a stool test to screen for colon cancer within the last year? ❑ Yes ❑ No

9. Do you use any medical equipment or medical devices? (i.e. cane, walker, wheelchair, bath chair, toilet seat, commode, diapers, hospital bed, pressure mattress, CPAP machine, oxygen, catheters)

❑ Yes ❑ No If Yes, what type? _____

10. In the past year, how many times have you been to the emergency room?

❑ None ❑ Once ❑ Twice ❑ Three or more

11. In the past year, how many times have you stayed overnight as a patient in the hospital?

❑ None ❑ Once ❑ Twice ❑ Three or more

12. What prescription medications do you take?

Current Medications List

Name of Medication	Strength and Frequency	Condition Medication Taken For	Physician who Prescribed Med

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Behavioral Health

13. Over the past month, how often have you been bothered by the following:	Not at all	Several days	Daily
Feeling down, depressed, or hopeless	❑	❑	❑
Trouble falling asleep or sleeping too much?	❑	❑	❑
Little interest or pleasure in doing things	❑ Yes	❑ No	
Do you or your family / friends have concerns about your memory?	❑ Yes	❑ No	

Activities of daily living

14. Who do you live with? _____

What is the relationship of the person or family member you live with? _____

15. Do you worry about having a place to live? ❑ Yes ❑ No

16. Do you worry about having enough food to eat? ❑ Yes ❑ No

17. Do you have transportation to and from your doctors' appointments? ❑ Yes ❑ No

Functional Assessment

18. How often do you need help with the following:	Never	Rarely	Sometimes	Always
Continence	❑	❑	❑	❑
Getting around your home	❑	❑	❑	❑
Feeding yourself	❑	❑	❑	❑
Getting in or out of bed or a chair	❑	❑	❑	❑
Caring for yourself, including bathing	❑	❑	❑	❑
Dressing yourself	❑	❑	❑	❑
Using the toilet	❑	❑	❑	❑