



FIDELIS CARE®

Health Risk Assessment

Please download, print, and complete all sections of this form.

Date: _____

Name (last, first, middle): _____

Street Address: _____

City: _____ State: _____ ZIP code: _____ Phone: _____

Date of Birth: _____ Member ID#: _____

Primary Care Provider's (PCP) Name: _____

1. How many times have you been to the hospital in the past six months? _____

2. How many times have you been to the emergency room in the past six months? _____

3. Do you have any future hospital visits or surgeries planned? Yes No
If so, when? _____

4. How would you rate your current health? Excellent Very good Fair Poor

Now we are going to ask you a few questions about your health.

5. Do you have asthma? Yes No

6. Do you have COPD? Yes No

7. Do you have diabetes? Yes No

8. Do you have seizures? Yes No

(Continued)

9. Have you had any memory problems? Yes No
10. Have you had a stroke? Yes No
11. Do you have heart failure (also known as congestive heart failure or CHF)? Yes No
12. Are you currently being treated for any type of cancer? Yes No
If yes, what type? _____
13. Are you on the organ transplant list? Yes No
14. Do you have hepatitis? Yes No
15. Do you have kidney failure? Yes No
16. Have you felt depressed, sad, down, hopeless, or blue for two weeks or more? Yes No
17. Do you have schizophrenia? Yes No
18. Do you have tuberculosis? Yes No
19. Do you have any kind of paralysis? Yes No
20. Do you have multiple sclerosis? Yes No
21. Are you living with HIV or AIDS? Yes No
22. Have you ever had lead poisoning? Yes No
23. Do you have sickle cell disease? Yes No
24. Do you have hemophilia? Yes No
25. Are you currently pregnant? Yes No
26. Do you take four or more prescription medications? Yes No
27. Do you have heart disease (also known as coronary artery disease or CAD)? Yes No
28. Do you currently use any medical equipment? (Do not count canes, walkers, crutches, nebulizers, or diabetic supplies.): Yes No
If so, please indicate what equipment: _____
29. Do you need help with any activities of daily living, such as bathing, taking medications, or eating?
 Yes No



When complete, please add postage and mail your survey to:

**ATTN: Fidelis Care
PO Box 31507
Tampa FL 33633-1205**

Fidelis Care complies with all applicable federal civil rights laws. We do not exclude or treat people in a different way based on race, color, national origin, age, disability or sex.

If English is not your first language, we can translate for you. We can also give you info in other formats. That includes Braille, audio and large print. Just give us a call toll-free. You can reach us at **1-888-453-2534**. For TTY, call **711**.

Si el español es su idioma materno, podemos traducir la información para usted. También podemos proporcionarle información en otros formatos, entre ellos, Braille, audio y letra grande. Solo llámenos, sin costo alguno. Puede comunicarse con nosotros llamando al **1-888-453-2534**. Para TTY, llame al **711**.

若您中文是您的第一語言，我們可以為您翻譯。我們也提供其他格式的資訊，包括點字版、音訊和大字印刷。請致電免費專線 **1-888-453-2534**。TTY 請撥打 **711**。