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)

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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

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Si el español es su idioma principal, podemos traducir para usted. Fidelis Care ofrece asistencia lingüística gratuita, ayudas y servicios auxiliares, materiales con letra más grande, traducción oral y otros formatos alternativos. Para obtener ayuda, llame al **1-888-453-2534** (TTY: **711**) de lunes a viernes, de 8 a.m. a 6 p.m.

如果中文是您的母語，我們可以爲您翻譯。Fidelis Care 提供免費的語言協助、輔助工具和服務、大字體印刷資料、口譯和其他替代格式。如需協助，請致電 **1-888-453-2534** (TTY：**711**)，週一至週五上午 8 點至下午 6 點。

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