



Health Risk Assessment (HRA)

Completing this may qualify you for rewards (see program details).

Date:		Member ID or MBI:		Plan Start Date:	
First Name:		Last Name:		Date of Birth:	
Gender:		Phone Number:		County:	
Preferred Language (optional):		Religion (optional):		Email (optional):	
Highest Education Level (optional):					

Section 1: About You (Personal Characteristics)

1 What is your race and/or ethnicity? *Select all that apply and enter details in the space provided.* (optional):

☐ American Indian/Alaskan Native *(for example, Navajo Nation, Nome Eskimo Community, etc.)*

☐ Asian *(for example, Korean, Chinese, Filipino, Indian, Vietnamese, etc.)*

☐ Black/African American *(for example, African American, Haitian, Ethiopian, etc.)*

☐ Hispanic or Latino *(for example, Mexican, Salvadoran, Puerto Rican, Cuban, etc.)*

☐ Middle Eastern or North African *(for example, Lebanese, Iranian, Egyptian, Syrian, etc.)*

☐ Native Hawaiian/ Pacific Islander *(for example, Native Hawaiian, Samoan, Fijian, etc.)*

☐ White *(for example, English, German, Irish, Italian, Polish, etc.)*

☐ Other Group, please write in:

Section 2: Health Conditions

2 Have you ever had any of these health problems? (Check all that apply)

☐ Asthma

☐ COPD

☐ Diabetes

☐ Prediabetes

☐ High Blood Pressure

☐ Cancer Type: _____

☐ Heart Failure

☐ Kidney Disease

☐ Dementia or Memory Loss

☐ Liver Disease

☐ Heart Disease

☐ Arthritis or Joint Problems

☐ Irregular Heartbeat

☐ Stroke (incl. Brain Bleed)

☐ Heart Attack (MI)

☐ Bladder Problems

☐ Bowel Problems

☐ Hearing Loss

☐ Obesity

☐ Seizures

☐ Paralysis

☐ HIV or AIDS

☐ Mental Health Disorder Type:

☐ Substance Use Disorder

☐ Other: _____

☐ Past Organ Transplant(s):

Transplant Date: _____

Which organ? _____

☐ None

Section 3: Your Health & Doctor Visits (Preventive Care)

3 How would you rate your current health?

☐ Excellent

☐ Fair

☐ Very Good

☐ Poor

☐ Good

4 How confident are you filling out medical forms by yourself?

☐ Extremely Confident

☐ Somewhat Confident

☐ Not Confident

5 In the event of a Medical emergency: (select one)

☐ I want to have life-support treatment

☐ I do not want life-support treatment

☐ I am unsure and would like more information

*Life support treatment means any medical procedure, device, or medication to keep me alive.



6	Have you had any problems with memory? ☐ Yes ☐ No	7	Do you have a good understanding of your healthcare? ☐ Yes ☐ No
8	When was your last check-up?	9	When was your last mammogram?
10	When was your last blood test?	11	When was your last colon cancer screening?
12	Do you regularly do any kind of physical activity or exercise? ☐ Yes ☐ No	13	Have you been offered a palliative care visit to help manage chronic conditions? ☐ Yes ☐ No
14	Overall, how comfortable are you with performing these activities of daily living?		
	Eating ☐ Can do independently ☐ Need Assistance		Brushing hair, brushing teeth, shaving, clipping nails, etc.? ☐ Can do independently ☐ Need Assistance
	Dressing and Undressing ☐ Can do independently ☐ Need Assistance		Getting in and out of bed and moving around freely? ☐ Can do independently ☐ Need Assistance
	Using the toilet ☐ Can do independently ☐ Need Assistance		Bathing or showering completely ☐ Can do independently ☐ Need Assistance
15	Do you require assistance with any of the following? (Check all that apply) ☐ Managing medications ☐ Managing finances ☐ Shopping for groceries or necessities ☐ Preparing meals ☐ Housekeeping or laundry ☐ Transportation to appointments or errands ☐ Using the telephone or other communication devices ☐ Managing appointments or daily activities ☐ None – Independent with all Independent Activity Daily Living with all of the above		
16	If you have diabetes or a heart condition, are you taking a statin (cholesterol medicine)? ☐ Yes ☐ No → If no, select all that apply below ☐ Side effects, allergy, or intolerance (e.g., muscle pain or weakness) ☐ Liver problems, End Stage Kidney disease, or dialysis ☐ Prediabetes or other blood sugar concerns ☐ Do not think I need a statin / cholesterol is normal ☐ Taking another cholesterol-lowering medication ☐ Cost issues or difficulty getting medication ☐ Other: _____	17	Were your eyes dilated at an exam in the last 2 years? ☐ Yes ☐ No If yes, Drs. Name: _____ Exam Date: _____ Was retinopathy found? ☐ Yes ☐ No
18	What was the A1C level from your last blood test? Test Date: _____ Level: _____	19	When was your last blood pressure reading? Reading Date: _____ BP level: ____/____ Location of Reading: ☐ Home ☐ Doctor's Office
20	How often do you use the following:		
	<u>Tobacco</u> ☐ Regularly ☐ Occasionally ☐ Never	<u>Alcohol</u> ☐ Regularly ☐ Occasionally ☐ Never	<u>Recreational Drugs</u> ☐ Regularly ☐ Occasionally ☐ Never
21	Have you received any of the following vaccines this year? ☐ Flu ☐ Pneumonia ☐ COVID ☐ None Other vaccine: _____		



22	If you do not get vaccinated regularly, why?	23	How would you describe your eating habits? ☐ Healthy and balanced ☐ Somewhat healthy ☐ Unhealthy or not regular meals
24	How many times have you been admitted to a hospital in the past 12 months? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ More than 5 times	25	How many times have you gone to the emergency room (ER) in the past 12 months? ☐ 0 ☐ 1-3 ☐ 4-7 ☐ More than 7 times
26	Have you had any stays at a Skilled Nursing Facility (SNF) or Acute Rehab Facility in the past 12 months? ☐ Yes ☐ No		
Section 4: Moving and Balance (Risk of Falling)			
27	Have you fallen in the past year? ☐ Yes ☐ No	28	Do you feel unsteady while walking or standing? ☐ Yes ☐ No
29	Do you use assistive devices to walk or stand? ☐ Yes ☐ No Type: _____	30	Do you hold onto furniture when walking at home? ☐ Yes ☐ No
31	Do you have trouble seeing clearly? ☐ Yes ☐ No	32	Have you had a vision test in the last year: ☐ Yes ☐ No
Section 5: Medicines, Allergies, & Pain			
33	Do you take prescription medicines? ☐ Yes ☐ No If yes, how many? _____ List all known medications: _____		
34	Do you get extra help from Medicare to pay for your medications? ☐ Yes ☐ No		
35	Do you ever have difficulty taking your medications exactly as prescribed? ☐ No ☐ Yes → If yes, select all that apply below. ☐ Cost ☐ Forgot to take/refill medication ☐ Side effects ☐ Medication not effective ☐ Difficulty obtaining medication ☐ Waiting for provider/refill authorization ☐ Doesn't understand medication instructions ☐ Too many medications/complex regimen ☐ Provider discontinued medication ☐ Other: _____	36	Do you have any side effects from your medications such as dizziness, sleepiness, dry mouth, constipation, blurry vision, confusion, or trouble thinking? (Common examples include some medicines for allergies, bladder problems, depression, sleep, or stomach issues.) ☐ Yes ☐ No ☐ Not sure If Yes: • Can you list the names of those medicines (or describe what they are for)? _____ Has your doctor talked with you about possibly changing or stopping any of these medicines? ☐ Yes ☐ No
37	Do you have any known allergies? ☐ Yes ☐ No If yes, list the allergens: _____	38	Do you currently have pain or discomfort? ☐ No ☐ Yes. If yes, where? _____ What is the level of pain on a scale from 0 – 10? _____ (0 = No Pain, 10 = Worst Ever)
Section 6: Support & Social Life			
39	Do you feel safe at home? ☐ Yes ☐ No	40	Do you have a caregiver helping you now? ☐ Yes ☐ No



Please Return this HRA in the self-addressed envelope provided.

			If yes, how many days each week? _____		
41	Who do you have to help you when needed? ☐ Family ☐ Friends ☐ Caregivers (ex: IHSS) ☐ No help				
42	Do you ever think your caregiver has a hard time giving you all the help you need? ☐ Yes ☐ No	43	How often do you speak with or see close friends/family? ☐ Less than once a week ☐ 1–2 times a week ☐ 3–5 times a week ☐ More than 5 times a week		
Section 7: Housing & Transportation					
44	What is your housing situation today? ☐ I have a steady place to live ☐ I have a place to live today, but I am worried about losing it in the future ☐ I do not have a steady place to live (<i>I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park</i>)				
45	In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (<i>check all that apply</i>) ☐ Yes, it has kept me from medical appointments or getting medications ☐ Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need ☐ No				
Section 8: Food & Utilities					
46	Within the past 12 months, you worried that your food would run out before you got money to buy more. ☐ Often true ☐ Sometimes true ☐ Never true				
47	In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home? ☐ Yes ☐ No ☐ Already shut off				
Section 9: Mood and Emotional Health					
48	In the past two weeks, how often have you been bothered by any of the following problems?				
	<i>Check one box for each statement:</i>	Not at all	Several days	More than half the days	Nearly every day
		0	1	2	3
	Lost interest or joy in things:	☐	☐	☐	☐
	Feeling down, depressed, or hopeless:	☐	☐	☐	☐

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