



## Health Assessment Survey

NAME  
ADDRESS  
CITY STATE ZIP

Dear Member:

Thank you for your membership in Preferred Care Gold. At Preferred Care we want to make sure you are getting the best health care possible. One way we do this is by getting to know you and helping you meet your unique health care needs.

Please help us with your health care by answering the following survey. There are no right or wrong answers. If you are not able to complete this survey by yourself, please have a family member or caregiver assist you.

The information you provide will remain **confidential** and will in no way effect your health benefits or your enrollment in Preferred Care Gold. Please return the survey in the enclosed self-addressed, postage-paid envelope.

When we receive your completed survey, a Preferred Care case manager will work closely with members who are identified as having specific health care needs. The case manager is a highly trained nurse clinician who is committed to working with our members to guide them through today's health care system. The case manager works closely with your PCP to coordinate your care. Your PCP always is directing your treatment, while the case manager provides additional support to both you and your PCP.

If you have any questions about the survey, please call Member Services at (585) 327-2480 or toll-free at 1-800-665-7924. For TTY/TDD access call (585) 325-2629.

Sincerely,

A handwritten signature in cursive script that reads "Carl Cameron".

Carl Cameron  
Associate Medical Director

***Please return the questionnaire in the envelope provided to:***

Corporate Research Department | Preferred Care | 220 Alexander Street | Rochester, NY 14607

1. In general, would you say your health is:  
**(Check one answer)**

- <sub>1</sub> Excellent
- <sub>2</sub> Very Good
- <sub>3</sub> Good
- <sub>4</sub> Fair
- <sub>5</sub> Poor

2. In the past 12 months, how many times have you stayed overnight as a **patient in a hospital?**

- <sub>1</sub> Never
- <sub>2</sub> 1 time
- <sub>3</sub> 2 up to 3 times
- <sub>4</sub> 3 or more times

3. In the past 12 months, how many times have you been **seen in the emergency room?**

- <sub>1</sub> Never
- <sub>2</sub> 1 time
- <sub>3</sub> 2 times
- <sub>4</sub> 3 or more times

4. In the past 12 months, how many times have you **visited a physician or clinic?**

- <sub>1</sub> Never
- <sub>2</sub> 1 time
- <sub>3</sub> 2 to 3 times
- <sub>4</sub> 4 to 6 times
- <sub>5</sub> 7 or more times

5. How long have you been a patient of your primary care doctor?

- <sub>1</sub> I am a new patient
- <sub>2</sub> Less than 2 years
- <sub>3</sub> Over 2 years

6. In the past 12 months, did you have diabetes?

- <sub>1</sub> Yes

<sub>2</sub> No

7. Have you ever had coronary heart disease (hardening of the arteries)?

<sub>1</sub> Yes

<sub>2</sub> No

<sub>9</sub> Don't Know

8. Have you ever had pains associated with the heart and chest (angina pectoris)?

<sub>1</sub> Yes

<sub>2</sub> No

<sub>9</sub> Don't Know

9. Have you ever had a heart attack (myocardial infarction)?

<sub>1</sub> Yes

<sub>2</sub> No

<sub>9</sub> Don't Know

10. Have you ever had any other heart attack?

<sub>1</sub> Yes

<sub>2</sub> No

<sub>9</sub> Don't Know

11. Is there a friend, relative or neighbor who would take care of you for a few days, if necessary?

<sub>1</sub> Yes

<sub>2</sub> No

12. Please check all those conditions for which you are **currently** receiving medical treatment.

<sub>1</sub> Breathing problems

<sub>2</sub> High blood pressure

<sub>3</sub> Heart problems

<sub>4</sub> Urinary problems (e.g. leaking urine)

<sub>5</sub> Arthritis

<sub>6</sub> Serious memory loss

<sub>7</sub> Ankle/leg swelling

<sub>8</sub> Cancer

<sub>9</sub> Dialysis

13. Do you live: **(Check one answer)**

- <sub>1</sub> Alone
- <sub>2</sub> With a spouse
- <sub>3</sub> With a son or daughter
- <sub>4</sub> With other family: \_\_\_\_\_
- <sub>9</sub> Other: \_\_\_\_\_

14. Do you have any adult children living **within a two hour drive?**

- <sub>1</sub> Yes
- <sub>2</sub> No

15. If you needed help, would you ask your children for assistance?

- <sub>1</sub> Yes
- <sub>2</sub> No

16. Do you live in: **(Check one answer)**

- <sub>1</sub> An independent house, apartment, condominium, or mobile home
- <sub>2</sub> An assisted-living apartment or board and care home
- <sub>3</sub> A nursing home
- <sub>9</sub> Other: \_\_\_\_\_

17. For each of the activities listed below, please check the box to indicate if you are able to do this (1) without help, (2) need some help, or (3) cannot do this at all without help.

	<b>(1) Able to do this without help</b>	<b>(2) Need some help</b>	<b>(3) Cannot do this at all without help</b>	
Bathing	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	A
Dressing	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	B
Eating	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	C
Toileting	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	D
Getting out of a chair	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	E
Getting out of bed	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	F
Walking	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	G
Climbing stairs	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	H
Taking medications	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	I
Meal preparation	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	J
Housekeeping chores	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	K
Shopping and errands	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	L
Doing laundry	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	M
Transportation	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	N
Money management	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	O

18. Do you receive assistance from friends or family for any of the above tasks?

- <sub>1</sub> Yes
- <sub>2</sub> No

19. How many times have you fallen in the last few months?

- <sub>1</sub> Never
- <sub>2</sub> 1 time
- <sub>3</sub> 2 or more times

20. Are you currently receiving Medical Assistance or Medicaid?

- <sub>1</sub> Yes  
<sub>2</sub> No  
<sub>9</sub> Don't Know

21. In general, how many different prescription medicines do you take regularly? (Only count those your physician told you to take)

- <sub>1</sub> None  
<sub>2</sub> 1 to 2  
<sub>3</sub> 3 to 4  
<sub>4</sub> 5 or more

22. Do you receive any shots regularly (for example, insulin or B12)?

- <sub>1</sub> Yes  
<sub>2</sub> No

23. Do you use a catheter, oxygen supplies, or inhalers?

- <sub>1</sub> Yes  
<sub>2</sub> No

24. Are you currently participating in any clinical trials (e.g., special medical procedures or drugs under exploration with a physician)?

- <sub>1</sub> Yes  
<sub>2</sub> No

25. In the past 6 months, have you lost 10 pounds without trying?

- <sub>1</sub> Yes  
<sub>2</sub> No  
<sub>9</sub> Don't Know

26. How is your eyesight? (This means eyesight while wearing glasses or contacts, if you use them.)

- <sub>1</sub> Excellent  
<sub>2</sub> Good  
<sub>3</sub> Fair  
<sub>4</sub> Poor  
<sub>5</sub> Do not wear glasses or contacts

27. Are you currently receiving any home health care services from a nurse or personal care aide?

- <sub>1</sub> Yes  
<sub>2</sub> No

28. Do you often feel sad or blue?

- <sub>1</sub> Yes  
<sub>2</sub> No

29. Are you?

- <sub>1</sub> Male  
<sub>2</sub> Female

30. What is your date of birth?

Month		Day		Year	

31. Do you need or want an interpreter to communicate with a doctor or health care practitioner?

- <sub>1</sub> Yes  
<sub>2</sub> No

32. What language do you speak most of the time at home?

- <sub>1</sub> English  
<sub>2</sub> Spanish  
<sub>3</sub> Italian  
<sub>4</sub> German  
<sub>5</sub> Other: \_\_\_\_\_

33. This survey was completed by:

- <sub>1</sub> Self/Member  
<sub>2</sub> Spouse of member  
<sub>3</sub> Other family member  
<sub>9</sub> Other: \_\_\_\_\_