



PO Box 15804, Tampa, FL 33684-9846

Health & Wellness Material

FRH22HATP1

Health Assessment Tool (HAT)

Please complete this annual survey. This information will help us understand your health needs. Your answers WILL NOT affect your benefits. We may share your information with your primary care provider(s). If you have any questions regarding this form, please call 1-800-401-2740. TTY: 711

Please disregard this request if you have recently mailed a completed Health Assessment Tool.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Phone number: \_\_\_\_\_

Member ID: \_\_\_\_\_

A. Physical Health Rating

1. On a usual basis, how do you rate your health? (check one) [ ] Excellent [ ] Good [ ] Fair [ ] Poor

2. What is your height? (whole numbers) \_\_\_\_\_ Feet \_\_\_\_\_ Inches 3. What is your weight? (whole numbers) \_\_\_\_\_ lbs.

B. Activities of Daily Living

4. How much help do you need with the following? (check one box for each activity)

Table with 4 columns: Activity, No Help Needed, Some Help Needed, Complete Help Needed. Rows include Bathing, Dressing, Eating, Getting out of Bed or Chair, Preparing Meals, Taking your Medicine, Using the Bathroom, Walking, Remembering & Decision Making.

5. If you need help, do you have someone close by or a caregiver who helps you? [ ] Yes [ ] No [ ] Hospice [ ] N/A

C. Health History & Treatment

6. How many times were you admitted to the hospital or Emergency Room in the past 12 months? (check one) [ ] 0 [ ] 1 time [ ] 2 times [ ] 3 times [ ] More than 3 times

7. When did you last see your Primary Care Physician? (check one) [ ] Less than 6 months [ ] More than 6 months [ ] 12 months ago or greater

If you have not seen your Primary Care Physician in the last 6 months, please call the office to schedule an appointment.

8. Do you currently use any medical equipment such as oxygen, electric bed or wheelchair in your home? [ ] Yes [ ] No

9. Are you receiving any nursing, therapy or home health care in your home? [ ] Yes [ ] No

10. Do you have blindness or trouble seeing even when wearing glasses? [ ] Yes [ ] No

11. Do you have deafness or trouble hearing even when wearing a hearing aid? [ ] Yes [ ] No

12. Do you get a flu shot annually? [ ] Yes [ ] No [ ] Unsure

13. Have you received a pneumonia shot in the past 5 years? [ ] Yes [ ] No [ ] Unsure

14. Have you had a Pap test in the past 2 years?  Yes  No  Unsure  N/A

15. Have you had a mammogram in the past 2 years?  Yes  No  Unsure  N/A

16. During the last month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?  None  1 Time  2 Times  3 Times  4+ Times

17. Have you had a colon cancer check in the last 10 years?  Yes  No  Unsure

18. Please check whether you have any of the following: (CHECK ALL THAT APPLY)

<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Depression or Other Mental Health Issues
<input type="checkbox"/> COPD or Emphysema or Chronic Bronchitis	<input type="checkbox"/> Organ Transplant
<input type="checkbox"/> Frequent Falls	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Attack or blocked arteries	<input type="checkbox"/> Skin Ulcer/Nonhealing Wound
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other _____

19. If you are concerned about your health, do you know what steps you can take to improve your health? (check one)

I am not concerned about my health.  I am concerned and know steps that I can take.

I am concerned, and my doctor is working with me.  I am concerned and I would like information on steps to improve my health.

20. Is there anything preventing you from taking steps to improve your health? (check one)

No  Yes, and I would like a call to discuss.  Yes, and I am working on it.

**D. Lifestyle & Well-being**

21. Do you use tobacco (smoke, chew, snuff, vape or in any other form)?  Yes  No  Want to quit

22. Does drinking alcohol interfere with your personal or work life?  Yes  No  N/A, I Don't Drink

23. Do you feel you get enough physical activity/exercise?  Yes  No  Want to improve

24. Do you feel that your diet supports a healthy lifestyle?  Yes  No  Want to improve

25. Do personal or family health issues result in loss of work/daily activities?  Yes  No  Unsure

26. Where do you currently live? (check one)  Private home  Assisted Living  Nursing Home

27. Do you feel safe in your home? (check one)  Yes  No

28. Do you always wear a seat belt when you are in a car? (check one)  Yes  No

29. Over the past 2 weeks, how often have you been bothered by any of the following feelings?

A. Feeling down, depressed or hopeless  Not at All  Several Days  More than Half the Days  Nearly Every Day

B. Little interest or pleasure in doing things  Not at All  Several Days  More than Half the Days  Nearly Every Day

30. Are you experiencing any of the following common effects or feelings of stress?  
(Check all that apply):  Anxiety  Drug/Alcohol Abuse  Irritability/Anger  Sadness /Depression  Social Withdrawal  
 Chest Pain  Headache  Muscle tension/Pain  Sleep Problem  Upset Stomach

***If you have any of the above symptoms or feel that you are depressed, please set up an appointment with your PCP.***

31. Would you like a call to talk about how you can get help for these feelings?  Yes  No

32. Would you like information on Health Care Advance Directives such as a Living Will?  Yes  No

**E. Demographics**

33. Do you identify with a particular cultural or spiritual group?  Yes, \_\_\_\_\_  No  Do not wish to answer

34. What is your preferred language?  English  Spanish  French Creole  Other: \_\_\_\_\_

35. What is your ethnicity?  Hispanic  Non-Hispanic  Other: \_\_\_\_\_  Decline to Answer

36. What race do you belong to?  African American  Alaskan Native  American Indian  Asian  Caucasian  
 Pacific Islander or Native Hawaiian  Other: \_\_\_\_\_  Decline to Answer