Member name_____

DOB _____ Member ID_____

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Medicare Advantage Health Assessment

1. How would you rate your overall health?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. How would you rate your physical health?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

3. What conditions have you had in the past or are currently receiving treatment for?

☐ Anxiety	☐ Asthma	☐ Bipolar disorder
☐ Cancer	☐ COPD/Emphysema	☐ Dementia
☐ Depression	☐ Diabetes	☐ Hearing problems
☐ Heart Disease	☐ Heart Failure	☐ High Blood Pressure
☐ Transplant	☐ Renal/Kidney failure	☐ Schizophrenia
☐ Stroke	☐ Vision problems	☐ None

4. Have you stayed in the hospital more than three times in the last year?
   ☐ Yes ☐ No

5. In the past six months, how many times did you visit the emergency room?
   ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

6. Do you take six or more medications?
   ☐ Yes ☐ No

7. How would you rate your pain on average? _____
   0-10 scale with 0=No pain and 10=Worst pain imaginable

8. How would you describe your dental health?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Have Dentures

9. How is your hearing?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Have Hearing Aids

10. How is your vision?
    ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Wear glasses
    ☐ Blind/Legally blind

11. How often do you get as much sleep as you want?
    ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

12 In the past month, how would you rate your sleep?
☐ Very Good ☐ Good ☐ Poor ☐ Very Bad

13 In the past six months, have you experienced leaking of urine? ☐ Yes ☐ No
If yes, have you spoken with your health care provider about leaking of urine?
☐ Yes ☐ No

14 Do you need help with any of the following?

Bathing	☐ No	☐ Yes, need help or equipment
Dressing	☐ No	☐ Yes, need help or equipment
Using the bathroom	☐ No	☐ Yes, need help or equipment
Getting in and out of a chair or bed	☐ No	☐ Yes, need help or equipment
Eating	☐ No	☐ Yes, need help or equipment
Taking your medicine	☐ No	☐ Yes, need help or equipment
Transportation	☐ No	☐ Yes, need help or equipment
Walking	☐ No	☐ Yes, need help or equipment
Using the telephone	☐ No	☐ Yes, need help or equipment
Household tasks *(cooking, laundry, chores)*	☐ No	☐ Yes, need help or equipment
Running errands or grocery shopping	☐ No	☐ Yes, need help or equipment
Managing your money *(paying bills, bank accounts)*	☐ No	☐ Yes, need help or equipment

15 For the activities above, do you get the help you need?
☐ I get all the help I need ☐ I could use more help
☐ I need more help ☐ I don't need any help

16 Do you have stairs or steps in your home? ☐ Yes ☐ No

17 In the past six months, have you fallen to the ground without being pushed?
☐ Yes ☐ No

18 How often do you feel unsteady when walking or have concerns with balance?
☐ Never ☐ Occasionally ☐ Daily ☐ All the time

19 How often do you feel fatigued?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

20 Have you lost weight without trying in the last three months? ☐ Yes ☐ No

21 Have you eaten less than normal over the past three months? ☐ Yes ☐ No
If yes, is this because of no appetite or chewing/swallowing difficulties? ☐ Yes ☐ No

22 How often did you exercise for at least 20–30 mins at least five days a week?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

23 Are you interested in help with an exercise program? ☐ Yes ☐ No

24 How often do you eat at least five servings of fruits and vegetables per day *(one serving is one-half cup)?*
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

25 How often do you eat foods high in fat such as whole milk, fried food, fatty meats?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

26 How often do you eat foods high in fiber *(i.e., whole grain bread and cereal, beans)*?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

27 Would you be interested in learning more about eating healthy? ☐ Yes ☐ No

28 Do you currently smoke or use tobacco products *(cigarettes, cigars, chew, vaping)*? ☐ Yes ☐ No If yes, are you interested in quitting? ☐ Yes ☐ No

29 How often did you have a drink containing alcohol in the last year?
☐ Never ☐ 2-4 times/month ☐ Monthly or less
☐ 2-3 times/week ☐ 4 or more times/week

30 If you do drink alcohol, how many drinks containing alcohol did you have on a typical day when you were drinking in the past year?
☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7–9 ☐ 10+

31 Do you ever think about quitting or changing how much you drink? ☐ Yes ☐ No

32 In the last two weeks, how often have you:

Felt nervous, anxious or on edge? ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every day
Not been able to stop or control worrying? ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every day
Had little interest or pleasure in doing things? ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every day
Felt down, depressed or hopeless? ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every day

33 What best describes your current living situation?

☐ Live alone ☐ Live with Family/Spouse

☐ Live with a non-relative ☐ Live in an assisted living facility

34 How often do you feel alone or isolated from others?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

35 How satisfied are you with your social activities and relationships?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

36 How often do you feel angry?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

37 How often do you feel stressed?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

38 Do you find you have to choose between buying groceries, medicine or paying bills? ☐ Yes ☐ No

39 What was the highest grade or level of school you completed?

☐ Eighth grade or less

☐ Some high school, did not graduate

☐ Some college or two-year degree

☐ Four-year college graduate (B.A., B.S.)

☐ More than Four-year degree

40 What is your current marital status?

☐ Married

☐ In serious or committed relationship, not married

☐ Divorced

☐ Separated

☐ Widowed

☐ Single

41 What is your primary language?

☐ English

☐ Spanish

☐ Other _____

Please return to:
Sanford Health Plan
Attn: Care Management
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