OPTIMUM HealthCare, Inc.

PO Box 15804, Tampa, FL 33684-9846

Health & Wellness Material

OPT24HRATP1

Health Risk Assessment Tool (HRAT)

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 1-866-245-5360. TTY: 711

Please disregard this request if you have recently mailed a completed Health Risk 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. Health History & Treatment

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

❑	Alzheimer's Disease/Dementia	❑	Diabetes	❑	Hospice
❑	Arthritis or pain in joints	❑	Lung Disease (Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or Chronic Bronchitis)	❑	Kidney Problems/Dialysis
❑	Asthma	❑	Frequent Falls	❑	Leaking urine or stool
❑	Cancer	❑	Heart Attack or blocked arteries	❑	Organ Transplant
❑	Congestive Heart Failure/Foot, Ankle, Leg Swelling	❑	High Blood Pressure	❑	Skin Ulcer/Nonhealing Wound
❑	COVID-19	❑	High Cholesterol or Triglycerides	❑	Stroke
❑	Depression or Other Mental Health Issues	❑	HIV/AIDS	❑	Other _____

5. 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.

6. Do you currently use any assistive devices and/or medical equipment (such as wheelchair, walker, cane, raised toilet seat, oxygen, or electric bed)? ❑ Yes ❑ No

7. Are you receiving any nursing, therapy or home health care in your home? ❑ Yes ❑ No

8. Do you have blindness or trouble seeing even when wearing glasses? ❑ Yes ❑ No

9. Do you have deafness or trouble hearing even when wearing a hearing aid? ❑ Yes ❑ No

10. Have you received: (check all that apply) ❑ Flu shot in the past year ❑ Pneumonia shot in the past 5 years ❑ Unsure

11. **A.** If you are currently bothered by pain, please tell us how bad the pain is, with 1 being very little pain, 5 being moderate pain and 10 being severe pain: ❑ I have no pain ❑ 1 to 3 ❑ 4 to 6 ❑ 7 to 10
B. If you have ongoing pain, are you working with a doctor on pain control? ❑ Yes ❑ No

12. Have you seen a Dentist in the past 12 months? ❑ Yes ❑ No
If you have not seen your Dentist, please call your dental provider to schedule an appointment.

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

14. Have you received an eye exam (with dilation) in the past year? ❑ Yes ❑ No ❑ Unsure

15. 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 would like information on steps to improve my health.

16. 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.

C. Activities of Daily Living

17. Do you need help with any of the following tasks? (Check all that apply):
❑ Bathing or dressing yourself ❑ Preparing meals ❑ Feeding yourself ❑ Using the bathroom ❑ Walking
❑ Getting up from a chair or bed ❑ Taking medication as prescribed ❑ Remembering and decision making

18. Do you have someone in your life that can provide you assistance with the tasks in Question #17 if you need help?
❑ No, I do not need help ❑ Yes, I have the help I need ❑ No, I need help that I don't have

D. Lifestyle & Well-being

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

20. Does drinking alcohol interfere with your personal or work life? ❑ Yes ❑ No ❑ I Don't Drink ❑ Want to quit

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

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

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

24. What is your living situation today? (check one)
❑ 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 am temporarily 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)

25. Do you feel safe where you live? (check one) ❑ Yes ❑ No

26. Within the past 12 months, have you worried that your food would run out before you got money to buy more? (check one)
❑ Often true ❑ Sometimes true ❑ Never true

27. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? ❑ Yes ❑ No

28. 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

29. 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.

30. Would you like information on how you can get help for these feelings? ❑ Yes ❑ No

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

E. Demographics

32. Do you identify with a particular cultural or spiritual group? ❑ Yes, _____ ❑ No ❑ Do not wish to answer

33. What is your preferred language? ❑ English ❑ Spanish ❑ French Creole ❑ Other: _____

34. What is your ethnicity? ❑ Hispanic ❑ Non-Hispanic ❑ Other: _____ ❑ Decline to Answer

35. What race do you belong to? ❑ African American ❑ Alaskan Native ❑ American Indian ❑ Asian ❑ Caucasian
❑ Pacific Islander or Native Hawaiian ❑ Other: _____ ❑ Decline to Answer