PO Box 15804, Tampa, FL 33684-9846

Health & Wellness Material

OPT20HATP1

Health Assessment Tool (HAT)

Please complete this 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 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.

4. Are you concerned about your current health? (check one)
   - ❏ No not at all. I do not have any serious health concerns.
   - ❏ Yes, I am frequently concerned about my health.
   - ❏ Yes, I am sometimes concerned about my health.
   - ❏ Yes, I am constantly concerned about my health.

5. How interested are you in making changes to improve your current health? (check one)
   - ❏ I am not interested in making any changes.
   - ❏ Have been thinking about it.
   - ❏ Have made a recent change to improve.
   - ❏ Thought about it in the past.
   - ❏ Making plans to improve.
   - ❏ I improved and am maintaining.

6. Do you know what steps you can take to improve your health? (check one)
   - ❏ I don't need to make changes.
   - ❏ My doctor is working with me.
   - ❏ I would like information on steps I can take to improve my health
   - ❏ I know steps that I can take.

7. Is there anything preventing you from taking steps to improve your health? (check one)
   - ❏ No, there is nothing specific preventing me from taking action.
   - ❏ I need help on how I can proceed.
   - ❏ I am working on issues that are preventing me from taking action.
   - ❏ I am already taking steps to improve my health.

8. 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

9. 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.

B. Activities of Daily Living

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

Activity	No Help Needed	Some Help Needed	Can't Do At All
Bathing	❏	❏	❏
Dressing	❏	❏	❏
Eating	❏	❏	❏
Getting out of bed or chair	❏	❏	❏
Preparing Meals	❏	❏	❏
Taking your medicine	❏	❏	❏
Using the Bathroom	❏	❏	❏
Walking	❏	❏	❏

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

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

13. Do you currently use any medical equipment such as an oxygen, electric bed or wheelchair in your home? ❑ Yes ❑ No

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

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

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

C. Health History & Treatment

Please check whether you have any of the following:

YES	NO		YES	NO	
❑	❑	Asthma	❑	❑	HIV/AIDS
❑	❑	Cancer	❑	❑	Kidney Problems
❑	❑	Congestive Heart Failure	❑	❑	Depression or Other Mental Health Issues
❑	❑	COPD or Emphysema or Chronic Bronchitis	❑	❑	Organ Transplant
❑	❑	Frequent Falls	❑	❑	Diabetes
❑	❑	Heart Attack or blocked arteries	❑	❑	Skin Ulcer/Nonhealing Wound
❑	❑	High Blood Pressure	❑	❑	Other ____________________

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

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

19. Do you get a flu shot annually? ❑ Yes ❑ No ❑ Unsure

20. Have you received a pneumonia shot in the past 5 years? ❑ Yes ❑ No ❑ Unsure

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

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

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

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

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

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

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

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

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

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