OPTIMUM HealthCare, Inc.

PO Box 15804, Tampa, FL 33684-9846

Health & Wellness Material

OPT22HATP1

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.

B. Activities of Daily Living

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

Activity	No Help Needed	Some Help Needed	Complete Help Needed
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)

❑	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 _____

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