

Health Needs Survey

- Please answer as many questions as you can. Leave blank the question(s) you cannot or choose not to answer.

Demographic Information

Name: _____

Address: _____

Date of Birth:
MM DD YYYYWhat is your gender? Male Female

Phone number: _____

Why are we doing this?

We want to provide you with high quality care that meets your needs. To do this, we need some information from you.

The information you provide us will be kept private. The information may be shared with members of your care team (primary care provider, specialists and case manager, if needed).

Your answers will be used to help us give you the best information and service possible. Please complete and return this survey.

Notice: Completion of this form is considered an approval to utilize the information, as needed, to best coordinate your care.

We use race, language and ethnic background to improve the quality of treatment and care that you need. We also use it to develop programs specific for you.

1. Which of these best describes your race?

- American Indian/Alaskan Native Asian Black/African American
 Native Hawaiian/Other Pacific Islander White Declined

2. Do you consider yourself Hispanic/Latino?

- Yes No Declined Unavailable/Unknown

3. What language do you speak? _____

Health History

4. Compared to others your age, how would you describe your overall health?

- Excellent
 Very Good
 Good
 Fair
 Poor

5. Do you have any of the special needs or disabilities listed below?

- Hearing Impairment
 Deaf
 Vision Impairment
 Blind
 Learning Disability
 None

6. How much do you weigh in pounds?

Pounds		
	<input type="radio"/> 0	<input type="radio"/> 0
<input type="radio"/> 100	<input type="radio"/> 10	<input type="radio"/> 1
<input type="radio"/> 200	<input type="radio"/> 20	<input type="radio"/> 2
<input type="radio"/> 300	<input type="radio"/> 30	<input type="radio"/> 3
<input type="radio"/> 400	<input type="radio"/> 40	<input type="radio"/> 4
<input type="radio"/> 500	<input type="radio"/> 50	<input type="radio"/> 5
<input type="radio"/> 600	<input type="radio"/> 60	<input type="radio"/> 6
<input type="radio"/> 700	<input type="radio"/> 70	<input type="radio"/> 7
	<input type="radio"/> 80	<input type="radio"/> 8
	<input type="radio"/> 90	<input type="radio"/> 9

7. How tall are you?

Feet	Inches
	<input type="radio"/> 0
	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 2
<input type="radio"/> 3	<input type="radio"/> 3
<input type="radio"/> 4	<input type="radio"/> 4
<input type="radio"/> 5	<input type="radio"/> 5
<input type="radio"/> 6	<input type="radio"/> 6
<input type="radio"/> 7	<input type="radio"/> 7
	<input type="radio"/> 8
	<input type="radio"/> 9
	<input type="radio"/> 10
	<input type="radio"/> 11

8. How often do you need to have someone help you read instructions, pamphlets or other written material from your doctor or pharmacy?

- Never
 Rarely
 Sometimes
 Often
 Always

Health History (continued)

Please tell us about your medical conditions

9. Has a doctor or other health care professional ever told you that you have any of the following?

Check all that apply

- | | | |
|--|---------------------------|--------------------------|
| Asthma | <input type="radio"/> Yes | <input type="radio"/> No |
| Bipolar Disorder or mood swings | <input type="radio"/> Yes | <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes | <input type="radio"/> No |
| Chronic Obstructive Pulmonary Disease (COPD) or other breathing problems | <input type="radio"/> Yes | <input type="radio"/> No |
| Diabetes or Sugar in Your Blood | <input type="radio"/> Yes | <input type="radio"/> No |
| Heart Disease | <input type="radio"/> Yes | <input type="radio"/> No |
| High Blood Pressure | <input type="radio"/> Yes | <input type="radio"/> No |
| High Cholesterol | <input type="radio"/> Yes | <input type="radio"/> No |
| HIV or AIDS | <input type="radio"/> Yes | <input type="radio"/> No |
| Major Depression or feeling sad most of the time | <input type="radio"/> Yes | <input type="radio"/> No |
| Obesity or that you are overweight | <input type="radio"/> Yes | <input type="radio"/> No |
| Schizophrenia | <input type="radio"/> Yes | <input type="radio"/> No |
| Sickle Cell Disease | <input type="radio"/> Yes | <input type="radio"/> No |
| You might need a transplant | <input type="radio"/> Yes | <input type="radio"/> No |

10. How many medications do you take each day? (include prescription and over-the-counter)

- None
 1 to 3
 4 to 7
 8 to 11
 11 or more

11. In the last three months, how often have you taken medications differently than they were prescribed?

- Daily
 Almost every day
 Sometimes
 Never

12. In the last three months, how often have you used medications not prescribed to you?

- Daily
 Almost every day
 Sometimes
 Never

13. Has your health caused you to miss time away from school, work or other activities within the last year?

- Yes
 No

Health History (continued)

14. In the past 12 months, how many times have you:

Gone to the Emergency Room?

- None 1 to 2 3 to 5 6 or more

Stayed overnight in a hospital?

- None 1 to 2 3 to 5 6 or more

15. Over the last 2 weeks, how often have you been bothered by any of the following?

Feeling sad, down, depressed or hopeless

- Not at all Several Days More than half the days Nearly every day

Having little or no pleasure in doing things

- Not at all Several Days More than half the days Nearly every day

Feeling nervous, anxious or on edge?

- Not at all Several Days More than half the days Nearly every day

Not being able to stop or control worrying?

- Not at all Several Days More than half the days Nearly every day

16. When was the last time that you had a colonoscopy?

- Never Within the last 10 years More than 10 years

For women only, otherwise skip to question 20.

17. Are you pregnant?

- Yes No

If no, are you planning to get pregnant in the next 12 months?

- Yes No

If yes, how long have you been pregnant?

- 1 to 3 months 4 to 6 months 7 to 9 months

18. When was the last time you had a mammogram?

- Never Within the last 2 years More than 2 years I have had a mastectomy

19. When was the last time you had a Pap Smear?

- Never Within the last 3 years More than 3 years I have had a hysterectomy

Health History (continued)

Please tell us about some of your daily habits

20. Have you had a flu or pneumonia vaccine in the last year?

- Yes No

21. How often do you walk, run or do other exercises for 30 minutes a day that make you breathe heavier or make your heart beat faster?

- Less than 1 time per week
 1 to 2 times per week
 3 times per week
 4 times per week
 5 or more times per week

22. Do you currently use tobacco products (cigarettes, chewing tobacco, cigars, pipes)?

- Yes, I currently use tobacco products

(For tobacco users only) In the last year, how many times have you quit using tobacco products for at least 24 hours? _____

(For tobacco users only) Are you seriously thinking of quitting tobacco use?

- Yes, within the next 30 days
 Yes, within the next 6 months
 No, not thinking of quitting
- No, I quit within the last 6 months
 No, I quit more than 6 months ago
 No, I have never used tobacco products

23. How often do you use alcohol, drugs or medications which affect your mood or help you relax?

- Daily Almost every day Sometimes Rarely or never

If the response is daily or almost every day only:

Have you felt you ought to cut down on your drinking or drug use?

- Yes No

Have people annoyed you by criticizing your drinking or drug use?

- Yes No

Have you felt bad or guilty about your drinking or drug use?

- Yes No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

- Yes No

Health History (continued)

24. Are you interested in making changes in any of the following areas? Check all that apply.

Controlling your use of alcohol or drugs

- Somewhat interested Very interested

Healthy eating

- Somewhat interested Very interested

Exercising or increasing physical activity

- Somewhat interested Very interested

Managing stress

- Somewhat interested Very interested

Smoking or chewing tobacco

- Somewhat interested Very interested

Getting to or maintaining a healthy weight

- Somewhat interested Very interested I am not interested in making any changes at this time.

Thank you for allowing us to learn more about you. We will use this information to help you live healthier.

Do you need help in these languages: العربية (Arabic); Bosanski (Bosnian);
 كوردی - بادینانی (Kurdish-Badinani); کوردی - سۆزانی (Kurdish- Sorani); Soomaali (Somali);
 Español (Spanish); Người Việt (Vietnamese)

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