HEALTH RISK ASSESSMENT

Please fill out this form. To help us meet your medical needs, BMC HealthNet Plan would like some information about you. **This information will not affect your eligibility and will only be shared with those authorized to see it**. When you see questions with boxes with different choices, put an "x" or fill in the box you choose. If you need another form or have a question, call Member Services at 1-888-566-0010.

What is your current mailing address?	
Are you currently homeless?	☐ yes ☐ no
Please list phone numbers to best reach you about your health needs:	Home Phone: ______ Cell Phone: ______ Work Phone: ______
What is your email address?	

1.) Head of Household Name/Member Name	
2.) Date of Birth	
3.) BMCHP ID#	
4.) Gender	☐ Male ☐ Female
5.) Are you hearing impaired?	☐ yes ☐ no
6.) Do you have a primary care doctor?	☐ yes ☐ no
7.) What is the name of your primary care doctor (PCP)?	
8.) Have you seen your PCP in the last 12 months?	☐ yes ☐ no
9.) In the last 12 months, have you missed a doctor's appointment?	☐ yes ☐ no
10.) Do you currently take any prescription medications on a regular basis?	☐ yes ☐ no
11.) Compared to others your age, how would you describe your health now?	☐ Excellent ☐ Good ☐ Fair ☐ Poor
12.) Do you have trouble doing any of the following because of your health? Please check as many as apply.	☐ Walking several blocks without stopping ☐ Bathing/Showering ☐ Sleeping ☐ Attending work or school ☐ Exercising or playing ☐ Eating ☐ Preparing meals ☐ Doing light household chores, such as vacuuming
13.) In the last 12 months, how many times did you visit an emergency room?	☐ Never ☐ 1-3 times ☐ 4-6 times ☐ More than 6 times
14.) In the last 12 months, have you stayed overnight in a hospital?	☐ yes ☐ no
15.) Do you use any medical equipment (wheelchair, crutches, walker or cane)?	☐ yes ☐ no
16.) If yes, briefly describe the medical equipment.	
17.) Are you currently being treated, or have you ever been treated, for any of the following? Please check as many as apply:	☐ ADD/ADHD ☐ Alcohol use or Drug use ☐ Anxiety ☐ Asthma ☐ Cancer ☐ Chronic Pain ☐ Congestive heart failure ☐ Diabetes ☐ High blood pressure ☐ High cholesterol ☐ HIV/AIDS ☐ Kidney Disease ☐ Migraines/Persistent headaches ☐ Obesity/Weight problems ☐ Other heart problems ☐ Stress ☐ Depression ☐ Trouble breathing ☐ Developmental delays/ Learning disability ☐ Sickle Cell Anemia

18.) Has anyone in your immediate family ever been treated for any of the following? (Your immediate family includes your mother, father, sister, brother, or your children – blood relatives only) Please check as many as apply:	☐ ADD/ADHD ☐ Alcohol use or Drug use ☐ Anxiety ☐ Asthma ☐ Cancer ☐ Chronic Pain ☐ Congestive heart failure ☐ Diabetes ☐ High blood pressure ☐ High cholesterol ☐ HIV/AIDS ☐ Kidney Disease ☐ Migraines/Persistent headaches ☐ Obesity/Weight problems ☐ Other heart problems ☐ Stress ☐ Depression ☐ Trouble breathing ☐ Developmental delays/ Learning disability ☐ Sickle Cell Anemia
19.) Are you pregnant? (If Male, skip to 23)	☐ yes ☐ no
20.) If Yes, when is your due date?	
21.) Do you have an OB/Gyn provider, a regular doctor or nurse (or a midwife) who is providing care during your pregnancy?	☐ yes ☐ no
22.) If Yes, please provide the following information about your OB/Gyn provider? (Name, address, phone)	
23.) Do you use tobacco products?	☐ yes ☐ no
24.) If Yes, would you like to get information to help quit smoking or tobacco use?	☐ yes ☐ no
25.) Would you like to get information about alcohol and/or substance abuse?	☐ yes ☐ no
26.) How would you describe your race? You may choose up to two options here. For example "White" or "Black", or "Asian" and "Hispanic".	☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black/African American ☐ Hispanic/Latino – Black ☐ Hispanic/Latino – White ☐ Hispanic/Latino – Other ☐ Native Hawaiian or Other Pacific Islander ☐ White/Caucasian
27.) How would you describe your ethnic background? You may choose up to two options here. For example "American" or "Mexican", or "Cuban" and "Puerto Rican".	
28.) What language would you prefer Boston Medical Center HealthNet Plan use for communicating with you?	
29. How often do you buckle your seat belt?	☐ Always ☐ Sometimes ☐ Never
30.) Do you have children under age 8 in your household?	☐ yes ☐ no
31.) If Yes, how often do you use a car seat for your children when driving?	☐ Always ☐ Sometimes ☐ Never
32.) Are you currently getting any services from any of the following state agencies?	☐ Massachusetts Commission for the Blind ☐ Massachusetts Commission for the Deaf and Hard of Hearing ☐ Massachusetts Rehabilitation Commission ☐ Department of Mental Health ☐ Department of Developmental Services ☐ Division of Children and Families ☐ Special Education ☐ Early Intervention Program ☐ Other (Please specify): ______________________