

Health Risk Screening

To ensure you (or someone you care about) are getting the best care, we'd like to ask you some questions. This should take about five minutes. All your answers will be private and won't affect health plan benefits.

Member name _____

Member address _____

Member phone _____ Member cell phone _____

Member email _____

Do you agree to receive email and text communications from Humana (e.g., reminders, letters and educational materials)? (Check all that apply.) Text Email

Member date of birth _____ Age _____

Member ID number _____

Emergency contact name _____ Phone _____

Date completed _____

Now we would like to ask some additional demographic and preference questions, which will help us personalize your health plan and care support experience.

1. What is your race and/or ethnicity? (One or more may be selected)

American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander

Asian

White

Black or African American

Other. Describe: _____

Hispanic or Latino

I choose not to answer this question

Middle Eastern or North African

2. Do you speak a language other than English at home?

Yes

No

I choose not to answer this question

2a. If yes, please describe:

Spanish

Tagalog

Arabic

Chinese

Vietnamese

Other: _____

2b. Do you or your caregiver need translation services?

Yes

No

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in Oklahoma

Health Risk Screening — continued

3. Do you or your caregiver have any of the following communication barriers?

(Select all that apply)

Hearing Impairment	Developmental Delays	None
Visual Impairment	Non-verbal	I choose not to answer this question
Other. Describe: _____		

4. What was your sex at birth?

Female	Unavailable
Male	I choose not to answer this question

5. What gender do you currently identify with? (Select all that apply)

Female	Female-to-male/transgender male/trans man
Male	Male-to-female/transgender female/trans woman
Other	Genderqueer/non-binary, neither exclusively male nor female
I choose not to answer this question	

6. What are your pronouns? (Select all that apply)

He/him/his	They/them/theirs	I choose not to answer this question
She/her/hers	Other	

7. What is your sexual orientation? (Select all that apply)

Straight or heterosexual	Bisexual	Do not know
Lesbian, gay, or homosexual	Something else	I choose not to answer this question

8. What is your housing situation today?

I have housing
I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
I choose not to answer this question

9. Are you worried about losing your housing?

Yes	No	I choose not to answer this question
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Health Risk Survey — continued

10. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?

Food	Yes	No
Clothing	Yes	No
Utilities	Yes	No
Child care	Yes	No
Medicine or any health care (Medical, Dental, Mental Health, Vision)	Yes	No
Phone	Yes	No
Other	Yes	No

describe: _____

I choose not to answer this question

11. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Select all that all that apply)

Yes, it has kept me from medical appointments

Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need

No

I choose not to answer this question

12. Over the last 2 weeks, how often have you been bothered by the following problems?

Little interest or pleasure in doing things

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

Feeling down, depressed, or hopeless

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

Feeling nervous, anxious or on edge

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

Not being able to stop or control worrying

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

13. How do you describe your health?

Excellent	Good	Poor
Very good	Fair	

Health Risk Survey — continued

14. (Females) Are you Pregnant?

Yes

No

15. What health conditions do you currently have? (Select all that apply)

Attention deficit hyperactivity disorder (ADHD)

Asthma

Bipolar disorder

Cancer

Chronic obstructive pulmonary disease (COPD)

Depression/anxiety

Diabetes

Heart failure

Hepatitis

High blood pressure

Human immunodeficiency

virus (HIV) or acquired

immune deficiency

syndrome (AIDS)

Kidney failure

Schizophrenia

Other:

16. Do you currently take prescription medicine?

Yes

No

N/A

16a. Are you able to obtain all medications when needed?

Yes

No

N/A

16b. Are you taking them as prescribed?

Yes

No

N/A

17. What type of health care appointments have you attended in the last 12 months?

(Select all that apply)

Physical health/medical — Appointment date(s) _____

Mental or behavioral health — Appointment date(s) _____

Dental — Appointment date(s) _____

18. Do you have any pending appointments or procedures?

Physical health/medical — Appointment date(s) _____

Mental or behavioral health — Appointment date(s) _____

Dental — Appointment date(s) _____

19. Do you or your caregiver need help arranging your health services?

Yes. Describe the help you need: _____

No

Health Risk Survey — continued

20. Have you visited the Emergency Room (ER) in the past 6 months? How many times and why?

1 time	3 times	5 times
2 times	4 times	More than 5 times

Describe why you went to the ER: _____

I haven't been to the ER in the past six months.

21. Have you stayed overnight in the hospital (not including the Emergency Department) in the past 6 months? If yes, how many times?

1 time	3 times	5 times
2 times	4 times	More than 5 times

Describe the reason for your hospital stay(s): _____

I haven't stayed overnight in the hospital.

22. Do you need assistance with any of the following? (Select all that apply)

Dressing	Mobility	Daily medications
Bathing/grooming	Cooking/preparing meals	Using the restrooms
Eating	Transfer	Other. Describe: _____

23. Do you have a caregiver?

Yes. What is your relationship to your caregiver? _____ No

23a. Do you and/or your caregiver feel physically and emotionally safe where you currently live?

Yes	Unsure
No	I choose not to answer this question

24. In the past year, have you been afraid of your partner, ex-partner, caregiver, or anyone in your household?

Yes	Unsure
No	I choose not to answer this question

25. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

Less than once a week	6 or more times a week
1 or 2 times a week	I choose not to answer this question
3 to 5 times a week	

25a. Would you like to talk with someone about this?

Yes	No
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Health Risk Survey — continued

26. Over the last year, have you wished you could stop or cut back on any of the following items? (Select all that apply)

Drinking alcohol

Using tobacco or nicotine products (like cigarettes, cigars, snuff, chew, electronic cigarettes, or vaping)

Gambling

Taking illegal drugs or prescription drugs for non-medical reasons

Other: _____

None of the above

