

America's 1st Choice

of South Carolina, Inc.

PO Box 15804, Tampa, FL 33684-9846

Health & Wellness Material

AFSHMO20HATP1

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 1-888-563-3289. TTY: 711.

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Gender: _____

Phone number: _____

Member ID: _____

Please disregard this request if you have recently mailed a completed Health Assessment Tool.

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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dressing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Getting out of bed or chair | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Preparing Meals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking your medicine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Using the Bathroom | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Depression or Other Mental Health Issues
<input type="checkbox"/>	<input type="checkbox"/>	COPD or Emphysema or Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Falls	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack or blocked arteries	<input type="checkbox"/>	<input type="checkbox"/>	Skin Ulcer/Nonhealing Wound
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	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