Today's Date: _____

ID#:_____

Name:_____

Address:_____

_____

_____

General Questions:

1. In general how would you rate your health? (check one)
   ○ A. Excellent ○ B. Good ○ C. Fair ○ D. Poor

2. Do you ever choose not to seek medical care because of religious or personal beliefs?
   ○ A. Yes ○ B. No

3. Have you had a flu shot this year or are you planning to receive one this year?
   ○ A. Yes ○ B. No

4. Have you had a pneumonia vaccine once in the last five years?
   ○ A. Yes ○ B. No

5. Have you ever had a breast cancer screening (mammogram)?
   ○ A. Yes ○ B. No

6. Have you ever had a colorectal cancer screening (colonoscopy)?
   ○ A. Yes ○ B. No

7. Do you exercise regularly, or take part in a physical exercise program?
   ○ A. No ○ B. Yes, fewer than 3 times a week
   ○ C. Yes, more than 3 times a week ○ D. Yes, daily

Health Conditions:

8. What health problems or medical conditions do you have now or have had in the past? Please check all that apply:

○ A. Anxiety	○ B. Asthma	○ C. Bi-Polar Disorder
○ D. Cancer	○ E. COPD/Emphysema	○ F. Coronary Artery Disease
○ G. Dementia	○ H. Depression	○ I. Diabetes
○ J. Hearing Problems	○ K. Heart Failure	○ L. Hypertension
○ M. Organ Transplant	○ N. Renal Failure	○ O. Schizophrenia
○ P. Stroke	○ Q. Vision Problems	

9. Do you find that you sometimes have to choose between buying your groceries or buying your medication?
   ○ A. Yes ○ B. No

10. Have you fallen in the past 12 months?
    (A fall is when your body goes to the ground without being pushed)
    ○ A. Yes ○ B. No

11. In the past 12 months, how many times did you visit a doctor or clinic?
    ○ A. Not at all (0) ○ B. One time (1)
    ○ C. Two or three times (2-3) ○ D. Four to six times (4-6)
    ○ E. Seven or more times (7+)

12. In the past 6 months have you stayed overnight as a patient in a hospital?
    ○ A. Yes ○ B. No

13. In the past 6 months how many separate times did you go to the Emergency Room to get medical attention?
    ○ A. Not at all (0) ○ B. One time (1)
    ○ C. Two or three times (2-3) ○ D. Four or more times (4+)

14. Has your doctor recently told you that you need to lose weight?
    ○ A. Yes ○ B. No

15. Are you on a special diet recommended by your doctor (low sodium, low cholesterol, low fat)?
    ○ A. Yes ○ B. No

16. Do you smoke tobacco? ○ A. Yes ○B. No
17. If yes, are you interested in quitting? ○ A. Yes ○B. No
18. Do you drink alcohol? ○ A. Yes ○B. No
19. If yes, is alcohol use a concern for you or others? ○ A. Yes ○B. No
20. Are you using any street drugs or abusing prescription? ○ A. Yes ○B. No
21. Have you ever been treated for substance abuse? ○ A. Yes ○B. No

22. During the past 4 weeks, how much did pain interfere with your normal activities?
    ○ A. Not at all ○ B A little bit ○ C. Moderately
    ○ D. Quite a bit ○ E. Extremely

Please indicate if you need assistance doing the following:

23. Walking? ○ A. Yes ○ B. No
24. Transportation? ○ A. Yes ○ B. No
25. Eating? ○ A. Yes ○ B. No
26. Dressing? ○ A. Yes ○ B. No
27. Bathing? ○ A. Yes ○ B. No
28. Using the toilet? ○ A. Yes ○ B. No

29. If you answered “Yes” to any of the above questions, do you have someone who can assist you?
    ○ A. Yes ○ B. No

30. Do you have difficulty remembering or recalling events?
O A. Yes O B. No

31. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor of pharmacy?
O A. Never O B. Sometimes O C. Usually O D. Always

Do you have any of the following symptoms?

32. In the past 2 weeks, have you had little interest or pleasure in doing things that you normally like to do<
O A. Yes O B. No

33. In the past 2 weeks, have you been feeling downhearted, depressed or "blue" more than usual?
O A. Yes O B. No

34. In the past 2 weeks, have you experienced a significant change in the amount you normally sleep, either trouble getting to sleep or sleeping too much?
O A. Yes O B. No

35. In the past 2 weeks, have you experienced a change in the amount you normally eat, either poor appetite or overeating?
O A. Yes O B. No

Legal Documents:

36. Do you have a Medical Power of Attorney (someone to make medical decisions for you in the event that you are unable)?
O A. Yes O B. No

37. Do you have a living will/advance directive (Documents that makes your health care wishes known)?
O A. Yes O B. No

38. Is a copy of your advance directive on file at your doctor's office?
O A. Yes O B. No

About You:

39. Who completed this survey form?
O A. Myself/Member O B. Relative of Member
O C. Friend of Member O D. Professional caregiver of Member

40. Do you (the Member) live:
O A. Alone O B. With Spouse
O C. With non relative O D. With other family member

41. What is your (the Member's) primary Language?
O A. English O B. Spanish O C. Other

42. What is the highest grade or level of school that you (the Member) have completed?
O A. 8th grade or less O B. Some high school, but did not graduate
O C. High school graduate or GED O D. Some college or 2 year degree
O E. 4 year college graduate O F. More than a 4 year college degree