Name | Member ID | Date

Health Questionnaire (1 of 4)

Please use only blue or black ink in the checkboxes. Do not use pencil or felt tip. Make an ☒ mark in the box(es) that best fits your answer. If necessary, you may have someone else help you fill out the survey. The questionnaire is completely optional; your SCAN benefits will not be affected in anyway if you complete and return the questionnaire or choose not to. SCAN will only share the information with your medical group.

Compared to other people your age, would you say your health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

How many different medicines do you take that a doctor prescribed for you?

- ☐ None
- ☐ 1-2
- ☐ 3-4
- ☐ 5-7
- ☐ 8 or more

Think about all the other non-prescription medicines that you take; that is, medicines that you can get without a prescription, like aspirin, vitamins, antacids or herbal remedies. **Do you take these medicines (mark all that apply)?**

- ☐ Pain medicines like aspirin, acetaminophen (Tylenol®), naproxen (Aleve®) or ibuprophen (Aleve®)
- ☐ Vitamins or mineral supplements
- ☐ Antacids or heartburn medicines (Mylanta®, Pepcid®, Prilosec®, Tums®)
- ☐ Herbal remedies or dietary supplements
- ☐ Cough and cold medicines
- ☐ Antihistamines or decongestants (Actifed®, Benadryl®, Sudafed®)
- ☐ Laxatives
- ☐ Diarrhea medicine

It can be difficult to take medicines as prescribed. **How often do you take the correct amount of prescription medications at the correct time?**

- ☐ Always
- ☐ Most of the time
- ☐ Sometimes
- ☐ About half the time
- ☐ Almost never

Even if you use hearing aids, how much difficulty do you have:

Hearing and understanding words in a normal conversation?

☐ None ☐ Some ☐ A great deal

Hearing words clearly over the telephone?

☐ None ☐ Some ☐ A great deal

Even with glasses, how much difficulty do you have:

Seeing well enough to read street signs at night?

☐ None ☐ Some ☐ A great deal

Reading a newspaper?

☐ None ☐ Some ☐ A great deal

About how many hours of exercise, including walking, do you get each week?

☐ None ☐ 1-2 hours ☐ 3 or more hours

How often do you use tobacco products?

☐ Never ☐ Quit ☐ Occasionally ☐ Daily

If you drink alcohol, how much do you drink? (1 drink = 12 oz. of beer **or** 5 oz. of wine **or** 1.5 oz. of liquor)

- ☐ 3 or more drinks a day
- ☐ 1-2 drinks a day
- ☐ 1-2 drinks a week
- ☐ 1-2 drinks a month
- ☐ Don't drink alcohol

Name | Member ID | Date

Health Questionnaire (2 of 4)

In the past six months, how much of the time:

Did pain interfere with your daily activities?

☐ None ☐ Sometimes ☐ Always

Did tooth, mouth or swallowing problems make it hard to eat?

☐ None ☐ Sometimes ☐ Always

Did you feel unsure of your balance?

☐ None ☐ Sometimes ☐ Always

Did you have urinary or bladder problems?

☐ None ☐ Sometimes ☐ Always

In the past six months, have you gained or lost 10 pounds or more without trying?

☐ Yes ☐ No

Over the last two weeks, how often have you been bothered by any of 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

Trouble falling or staying asleep or sleeping too much

☐ Not at all ☐ More than half the days

☐ Several days ☐ Nearly every day

Do you have family, friends or others you can share problems and joys with or who you can turn to for help?

☐ Yes ☐ No

How often do you help a relative or friend who is disabled or can't perform daily activities like shopping, getting to the doctor, paying bills, chores or personal needs?

☐ Seldom or never ☐ 2-6 times a week

☐ Once a month ☐ Every day

☐ Once a week

How often does a family member or friend help you with things like shopping, getting to the doctor, paying bills, chores or personal needs?

☐ Seldom or never ☐ 2-6 times a week

☐ Once a month ☐ Every day

☐ Once a week

Which of the following describes you best?

☐ Must stay in bed all or most of the time

☐ Must stay in the house all or most of the time

☐ Need the help of another person in getting around inside or outside the house

☐ Need the help of a special aid, like a cane or wheelchair, in getting around inside or outside the house

☐ Don't need the help of another person or a special aid but have trouble getting around freely

☐ Not limited in any of these ways

Have you prepared a living will or advance directive? These are written instructions for your care in the event you are not able to speak for yourself.

☐ Yes ☐ No

If you would like information regarding an advance directive, please refer to the Five Wishes brochure included in your new member packet or talk to your doctor. You can also order a copy from www.scanhealthplan.com.

Name | Member ID | Date

scan HEALTH PLAN | Health Questionnaire (3 of 4)

Because of health or physical problem(s), is it difficult to do the following activities?

	No, not difficult	Yes, difficult	Unable to do
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Eating	☐	☐	☐
Getting in and out of chairs	☐	☐	☐
Walking	☐	☐	☐
Using the toilet	☐	☐	☐
Preparing a meal	☐	☐	☐
Shopping	☐	☐	☐
Doing housekeeping chores	☐	☐	☐
Using transportation	☐	☐	☐

Has a doctor ever told you have/had the following (mark all that apply)?

- ☐ Alzheimer's disease, dementia or serious memory problems
- ☐ Arthritis or rheumatism
- ☐ A broken hip
- ☐ Cancer, other than skin cancer
- ☐ Circulation problems
- ☐ Congestive heart failure
- ☐ Coronary artery disease or hardening of the arteries
- ☐ Diabetes or high blood sugar
- ☐ A heart attack or myocardial infarction
- ☐ High blood pressure or hypertension
- ☐ Lung conditions, including emphysema, asthma or pulmonary disease (COPD)
- ☐ Osteoporosis or bone weakness
- ☐ A stroke or mini-stroke

During the past year, how many times did you:

Fall down to the ground?

☐ None ☐ 2-3 times
☐ Once ☐ More than 3 times

Go to an emergency room?

☐ None ☐ 2-3 times
☐ Once ☐ More than 3 times

Get admitted to a hospital?

☐ None ☐ 2-3 times
☐ Once ☐ More than 3 times

Get admitted to a nursing home or convalescent home?

☐ None ☐ 2-3 times
☐ Once ☐ More than 3 times

In the past year, have you had any of the following (mark all that apply)?

	Yes	No	Unsure or N/A
A flu or influenza shot	☐	☐	☐
Your blood pressure checked	☐	☐	☐
Any blood tests done	☐	☐	☐
A test for blood in your stool	☐	☐	☐
An eye exam	☐	☐	☐
A hearing exam	☐	☐	☐
A dental exam	☐	☐	☐
A prostate exam (men only)	☐	☐	☐

Name | Member ID | Date

scan HEALTH PLAN | Health Questionnaire (4 of 4)

When, if ever, did you last have the following tests?

A colon cancer screening/colonoscopy

- ☐ Never
- ☐ 1-2 yrs
- ☐ 5-10 yrs
- ☐ Less than 1 yr
- ☐ 2-5 yrs

A mammogram (women only)

- ☐ Never
- ☐ 1-2 yrs
- ☐ 5-10 yrs
- ☐ Less than 1 yr
- ☐ 2-5 yrs

A Pap test (women only)

- ☐ Never
- ☐ 1-2 yrs
- ☐ 5-10 yrs
- ☐ Less than 1 yr
- ☐ 2-5 yrs

Have you ever had the pneumonia vaccine?

- ☐ Yes
- ☐ No
- ☐ Not sure

What best describes your current living arrangement?

- ☐ Live alone
- ☐ Live with spouse or significant other
- ☐ Live with other family members
- ☐ Live with my child or children
- ☐ Live with others, not family members

In the past year, have you had any of the following (mark all that apply)?

- ☐ Married
- ☐ Separated
- ☐ Widowed
- ☐ Never married
- ☐ Divorced

What best describes your ethnic makeup?

- ☐ Native American or Alaskan native
- ☐ African American or black
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Hispanic or Latino
- ☐ White or Caucasian
- ☐ Chinese
- ☐ Filipino
- ☐ Korean
- ☐ Vietnamese
- ☐ Multiracial
- ☐ Other
- ☐ Prefer not to answer

What languages do you prefer to use for health communication?

English	☐ Reading	☐ Speaking
Spanish	☐ Reading	☐ Speaking
Other:	☐ Reading	☐ Speaking

Please specify "other."

Did you need someone to help you fill out this questionnaire?

- ☐ Yes
- ☐ No

Thank you for helping us provide you with better healthcare.