Name | Member ID | Date

Health Survey (1 of 7)

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 Health Plan® 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.

What's your preferred language for:

Reading?

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Prefer not to answer
- ☐ Other (please explain): _____

Speaking?

- ☐ English
- ☐ Spanish
- ☐ Mandarin
- ☐ Cantonese
- ☐ Arabic
- ☐ Armenian
- ☐ Cambodian
- ☐ Farsi (Persian)
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Russian
- ☐ Tagalog
- ☐ Vietnamese
- ☐ American Sign Language (Braille)
- ☐ Other
- ☐ Prefer not to answer
- ☐ Other (please explain): _____

What ethnicity do you identify as?

- ☐ Caucasian/white
- ☐ Hispanic or Latino
- ☐ Chinese
- ☐ African American/black
- ☐ Korean
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Laotian
- ☐ Vietnamese
- ☐ Filipino
- ☐ Japanese
- ☐ American Indian
- ☐ Alaska native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Mixed race
- ☐ Prefer not to answer
- ☐ Other (please explain): _____

What's your current marital status?

- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Never married
- ☐ Prefer not to answer

What best describes your current living arrangements?

- ☐ 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
- ☐ Prefer not to answer

What is your housing situation today?

- ☐ I have housing
- ☐ I do not have housing (stay with others, in a hotel, in a shelter, on the street, etc.)
- ☐ Prefer not to answer

Can you live safely in and move easily around your home?

- ☐ Yes
- ☐ No

scan HEALTH PLAN®

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Health Questionnaire (2 of 7)

If no, does the place where you live have (check all that apply):

- [ ] Good lighting
- [ ] Good heating
- [ ] Good cooling
- [ ] Rails for stairs or ramps
- [ ] Hot water
- [ ] An indoor toilet
- [ ] A door to the outside that locks
- [ ] Stairs to get into your home or stairs inside your home
- [ ] An elevator
- [ ] Space to use a wheelchair
- [ ] Clear exits for leaving your home

Are you worried about losing your housing?

- [ ] Yes
- [ ] No
- [ ] Prefer not to answer

Do you sometimes run out of money to pay for food, rent, bills and medicine?

- [ ] Yes
- [ ] No
- [ ] Prefer not to answer

In general, what's most important to you in regards to your health?

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

- [ ] Excellent
- [ ] Fair
- [ ] Very good
- [ ] Poor
- [ ] Good

If you checked "fair" or "poor," please explain your concerns:

How many times per week do you exercise or do any physical activity, including walking or even gardening, for at least 15 minutes?

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7+

How often do you use tobacco products?

- [ ] Never
- [ ] Quit
- [ ] Occasionally
- [ ] Daily
- [ ] Prefer not to answer

How often do you consume alcohol?

- [ ] Never
- [ ] Quit drinking alcohol
- [ ] Rarely
- [ ] Occasionally
- [ ] Weekly
- [ ] One drink daily
- [ ] Two or more drinks daily
- [ ] Prefer not to answer

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

- [ ] No
- [ ] Lost
- [ ] Gained

During the past six months, how often did pain interfere with your daily activities?

- [ ] None of the time
- [ ] All of the time
- [ ] Some of the time

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Health Questionnaire (3 of 7)

Rate your level of pain on a 1-10 scale, with "1" meaning "no pain" and "10" meaning "extreme pain."

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10

Where is your pain?

How are you managing your pain (select all that apply)?

- ☐ Prescription medication
- ☐ Over-the-counter medication
- ☐ Exercise
- ☐ Physical therapy
- ☐ Alternative therapy
- ☐ Pain management
- ☐ Rest
- ☐ No treatment
- ☐ Other (please explain):

Comments:

Are you afraid of falling?

- ☐ Yes
- ☐ No

If yes, please explain:

How many times have you fallen to the ground in the last year?

- ☐ None
- ☐ Once
- ☐ Twice
- ☐ Three or more times

If yes, have you fallen in the last month?

- ☐ Yes
- ☐ No

In the past year, how many times have you:

Gone to an emergency room?

- ☐ None
- ☐ Once
- ☐ Twice
- ☐ Three or more times

Been admitted to the hospital (unplanned)?

- ☐ None
- ☐ Once
- ☐ Twice
- ☐ Three or more times

Been admitted to a nursing home (skilled-nursing facility or rehabilitation center)?

- ☐ None
- ☐ Once
- ☐ Twice
- ☐ Three or more times

Have you chosen someone, like a family member, who can make healthcare decisions for you if you're not able?

- ☐ Yes
- ☐ No

Advance healthcare directives are written instructions describing the healthcare you'd like to receive if you're not able to speak for yourself. Which of these have you completed (select all that apply)?

- ☐ None
- ☐ Power of attorney for healthcare
- ☐ Durable power of attorney
- ☐ Prepare for Your Care
- ☐ Physician's orders for life-sustaining treatment (POLST)
- ☐ Do not resuscitate (DNR)
- ☐ Other (please explain):

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Health Questionnaire (4 of 7)

Does your family and/or your primary care doctor know about these documents?

- [ ] Yes
- [ ] No

The following questions are about managing your health conditions.

Do you need help filling out health forms?

- [ ] Yes
- [ ] No

If you answered yes, please tell us why you need help filling out the health forms (select all that apply):

- [ ] Forms are not in my language
- [ ] It's difficult to understand terms on the form
- [ ] It's hard to see (visual)
- [ ] It's difficult to answer all the questions
- [ ] Other (please explain):

Do you need help answering questions during a doctor's visit?

- [ ] Yes
- [ ] No

If you answered yes, please tell us why you need help answering questions during a doctor's visit (select all that apply):

- [ ] Doctor/staff do not speak my language
- [ ] It's difficult to understand some things the doctor says
- [ ] It's difficult to answer all the questions
- [ ] Other (please explain):

Do you have any concerns regarding the management of your health that you feel have not been addressed by your primary care doctor or a specialist?

- [ ] Yes
- [ ] No

If yes, please explain:

Do you need help taking your medicines?

- [ ] Yes
- [ ] No

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

- [ ] 1-2
- [ ] 3-4
- [ ] 5-6
- [ ] 7-8
- [ ] 9-11
- [ ] More than 12

Do you find it difficult taking your medicines as prescribed?

- [ ] Never
- [ ] Sometimes
- [ ] Most of the time
- [ ] All the time

What prevents you from taking your medicines as prescribed (select all that apply)?

- [ ] Nothing
- [ ] Scheduling
- [ ] Side effects
- [ ] Transportation/access
- [ ] Not sure how to take medicines
- [ ] Visual problems
- [ ] Cost
- [ ] Do not believe in medication
- [ ] Difficulty filling prescriptions
- [ ] Forgetfulness
- [ ] No system for managing medication
- [ ] Other (please explain):

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Health Questionnaire (5 of 7)

Are you experiencing symptoms or side effects related to any of your medicines?

- ☐ Never
- ☐ Most of the time
- ☐ Sometimes
- ☐ All the time

If yes, please explain:

Which of the following over-the-counter or nonprescription medications are you currently taking (select all that apply)?

- ☐ Benadryl®/dimenhydrinate
- ☐ Tylenol® PM/Unisom®
- ☐ Pseudoephedrine
- ☐ Advil®/naproxen (three times per/day)
- ☐ Dramamine®
- ☐ Dimetapp®
- ☐ St. John's wort
- ☐ Marijuana
- ☐ None

Comments:

Have you had any changes in thinking, remembering or making decisions?

- ☐ Yes
- ☐ No

If yes, how has it changed your daily life (select all that apply)?

- ☐ Difficulty getting out of bed
- ☐ Difficulty with self-care
- ☐ Difficulty with household tasks (cleaning, cooking)
- ☐ Difficulty managing mail or bills
- ☐ Cannot drive anymore
- ☐ Difficulty with social events
- ☐ Other (please explain):

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
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Feeling down, depressed or hopeless?

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

Over the past month (30 days), how many days have you felt lonely?

- ☐ None; I never feel lonely
- ☐ More than half the days (15 days)
- ☐ Less than five days
- ☐ Most days; I always feel lonely

In the past year, have you had the following (select all that apply)?

- ☐ Dental exam
- ☐ Hearing exam
- ☐ Eye exam
- ☐ Pneumonia shot
- ☐ Flu shot/influenza
- ☐ Prostate exam

When did you last have the following text or screening:

Mammogram?

- ☐ Never
- ☐ 2-5 years ago
- ☐ Less than a year ago
- ☐ 5-10 years ago
- ☐ 1-2 years ago
- ☐ No longer recommended

Pap test?

- ☐ Never
- ☐ 2-5 years ago
- ☐ Less than a year ago
- ☐ 5-10 years ago
- ☐ 1-2 years ago
- ☐ No longer recommended

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Health Questionnaire (6 of 7)

Colorectal cancer screening, including a stool test or colonoscopy?

- ☐ Never
- ☐ 2-5 years ago
- ☐ Less than a year ago
- ☐ 5-10 years ago
- ☐ 1-2 years ago
- ☐ No longer recommended

Have you seen your primary care doctor in the last six months?

- ☐ Yes
- ☐ No

If yes, write down the date you saw your doctor, if you remember it:

Do you need help with any of these activities (select all that apply):

Walking?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Going up or down stairs?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Getting out of a bed or a chair?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Taking a bath or shower?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Using the toilet?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Brushing your teeth/hair and/or shaving?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Getting dressed?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Eating?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Making meals or cooking?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Shopping and getting food?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Washing dishes or clothes?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Doing house or yard work?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Using the phone?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

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Health Questionnaire (7 of 7)

Getting a ride to the doctor or to see your friends?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Going out to visit family or friends?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Writing checks or keeping track of money?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Keeping track of appointments?

- ☐ Unable to do this activity
- ☐ Yes, I have difficulty
- ☐ No, I do not have any difficulty

Does hearing or vision impact your ability to complete daily tasks?

- ☐ Hearing
- ☐ Both
- ☐ Vision
- ☐ Neither

Please explain:

During the past six months, how much did leaking urine make you change your daily activities or interfere with your sleep?

- ☐ None
- ☐ Some, but doesn't interfere
- ☐ Interferes with sleep
- ☐ Interferes with activities
- ☐ Interferes with both

For the areas you indicated you need assistance, are you getting all the help you need with these actions?

- ☐ Yes
- ☐ Not applicable
- ☐ No

Do you have family members or others willing and able to help you when you need it?

- ☐ Yes
- ☐ Not applicable
- ☐ No

If you have a caregiver, do you ever think your caregiver has a hard time giving you all the help you need?

- ☐ Yes
- ☐ Not applicable
- ☐ No

Are you afraid of anyone or is anyone hurting you?

- ☐ Yes
- ☐ No

If yes, please explain:

Is anyone using your money without your ok?

- ☐ Yes
- ☐ No

If yes, please explain:

SCAN Health Plan is an HMO Plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.

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