Personal Health Survey

MediGold
Medicare made *easy*

To better understand your health care needs and to help us connect you with the right resources, **please return this survey within the next seven days.** We've enclosed a postage paid envelope for your convenience. Your responses in no way affect your MediGold coverage or premium amount. Thank you and we look forward to being your health care partner.

Last name: _____ First name: _____ Middle Initial: _____

Birth date: (MM/DD/YYYY) _____ _____ Male _____Female

Member ID: _____

Name of Primary Care Provider: _____

Are you a Veteran? ___yes___no

Please fill in one circle for each answer unless otherwise indicated.

1. **Height** _____
   a. **Has your height decreased?** ___yes ___no ___don't know
2. **Weight** _____
   a. **Has your weight:** ___increased ___decreased ___stayed the same ___don't know
3. **Have you had a flu shot since last July?** ___yes ____no ___don't know
4. **Have you had a shot to prevent pneumonia?** ___yes ___no ___don't know
5. **Have you had a mammogram in the last two years?** ___yes ___no ___don't know
6. **Have you ever had a colorectal cancer screening?** ___yes ___no
   a. **If yes, check all that apply:**
      ___ fecal occult blood test (FOBT) in the last calendar year
      ___ flexible sigmoidoscopy in the last 5 years
      ___ colonoscopy in the last 10 years
      ___ DNA based colorectal screening in the last 3 years
7. **In the past seven days, did you need help from others to perform everyday activities?**
   ___yes ___no
   a. **If yes, check all that apply:**
      ___ eating ___ getting dressed ___ grooming ___ bathing ___ walking
      ___ using the toilet ___ doing laundry ___ housekeeping ___ banking ___ shopping
      ___ using the phone ___ food preparation ___ transportation ___ taking your own medications
8. **How many different doctors did you visit in the last 12 months?**
   ___none ___one ___two ___three or more

MediGold is a Medicare Advantage organization with a Medicare contract. Enrollment in MediGold depends on contract renewal. NF_051_22_C (welcome)

9. **What language do you feel most comfortable speaking with your doctor or health care provider?**

___English ___Spanish ___Other (please write it in) _____

10. Please check all conditions for which you are currently receiving medical treatment:

___ ankle/leg swelling or pain
___ anxiety
___ arthritis
___ cancer
___ congestive heart failure
___ depression
___ shortness of breath
___ diabetes or high blood sugar
___ kidney problems
___ heart disease
___ high blood pressure
___ wound that is not healing
___ lung disease
___ stroke

11. **In the past six months, how many falls or near falls have you had?** ___ none ___one ___two or more

12. **Are you having any problems with walking or balance?** ___yes ___no

13. In the past two weeks, how often have you felt down, depressed or hopeless?

___almost all of the time ___most of the time ___some of the time ___almost never

14. In the past two weeks, how often have you felt little interest or pleasure in doing things?

___almost all the time ___most of the time ___some of the time ___almost never

15. Are you using any of the following special equipment? Please check all that apply.

___ diabetes supplies
___ feeding pump
___ hospital bed
___ nebulizer machine
___ oxygen
___ scooter
___ walker/cane
___ wheelchair
___ other (please write it in) _____

16. **Do you follow a doctor recommended diet?** ___yes ___no

a. **If yes, please select all that apply:**

___ low fat ___low salt ___low sugar ___other (please write it in) _____

17. **In the past seven days, have you felt pain?** ___yes ___no

a. **If yes, are you receiving treatment for the pain?** ___yes ___no

18. **Have you talked with your doctor in the last 6 months about exercise or physical activity?** ___yes ___no

19. **In the last 30 days, have you used tobacco or a smokeless tobacco product?** ___yes ___no

20. **How many prescription medicines do you take each day?**

____ none ___one ___two ___three ___four or more

21. **MEN: How many times in the past year have you had 5 or more drinks in a day?**

____ none ___one ___two ___three ___four or more

22. **WOMEN: How many times in the past year have you had 4 or more drinks in a day?**

____ none ___one ___two ___three ___four or more

23. **Would you like more information for a living will and/or a durable power of attorney for health care?**

___yes ___no ___already have

FOR OFFICE USE ONLY: DATE COMPLETED _____