Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

Healthy Blue Personal Health Assessment Form

Thank you for choosing Healthy Blue. This health information form will help your doctors and us give you the best possible care.

Answer these questions the best you can. Once you complete the form, please mail the form to the following:

Healthy Blue
ATTN: Quality Director, AX-310
PO Box 100317
Columbia, SC 29202-3317

Or fax it to 803-870-6510.

If you have questions about this form, call Customer Service at 866-781-5094 (TTY: 866-773-9634) Monday – Friday from 8 a.m. – 6 p.m.

You can earn a $20 reward through our Healthy Rewards program for filling out this form! To learn how to sign up for the Healthy Rewards program and start earning rewards for other health activities, visit www.HealthyBlueSC.com.

Section 1: Member Information

Last name _____ First name _____

Date of birth _____ Phone number _____ Healthy Blue Member ID number _____

Email address _____

Street address _____

City, state and ZIP code _____

Section 2: Additional Information

Are you Hispanic or Latino?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

What is your race?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic

- [ ] Native Hawaiian or other Pacific Islander
- [ ] White
- [ ] Other race

What is your age?

- [ ] Under 30 years
- [ ] 30 – 39 years
- [ ] 40 – 49 years
- [ ] 50 – 59 years
- [ ] 60 or more years

What sex were you assigned on your original birth certificate?

- [ ] Male
- [ ] Female
- [ ] Choose not to say

What gender do you identify as?

- [ ] Male
- [ ] Female
- [ ] Transgender male/trans man/female to male
- [ ] Transgender female/trans woman/male to female
- [ ] Genderqueer, neither exclusively male nor female
- [ ] Additional gender category/other
- [ ] Choose not to say

Do you have a sexual orientation that you would like us to know about so we can address your health in a personalized way?

- [ ] Straight or heterosexual
- [ ] Lesbian, gay or homosexual
- [ ] Bisexual
- [ ] Something else
- [ ] Choose not to disclose
- [ ] Don't know

What language are you most comfortable reading and speaking?

- [ ] English
- [ ] Spanish
- [ ] Other

How tall are you without shoes (in inches)? _____

How much do you weigh (in pounds)? _____

Do you know your body mass index (BMI)? _____

In general, how do you rate your health?

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

Do you have a primary care provider (PCP)?

- ☐ Yes
- ☐ No

How comfortable are you in being able to read and understand information from your PCP about your conditions and medications?

- ☐ I have no trouble.
- ☐ English is not my main language.
- ☐ I can read health information, but I sometimes have trouble understanding it.
- ☐ I have trouble reading but can understand language if explained to me out loud.
- ☐ I have someone who helps me read and understand the information.
- ☐ I often have trouble reading or understanding medical information.
- ☐ I would like help with learning to read and understand.

Are you currently pregnant?

- ☐ Yes
- ☐ No

Have you had a breast cancer screening or mammogram in the past year?

- ☐ Yes
- ☐ No
- ☐ Does not apply

Have you had a cervical screening or Pap smear in the past year?

- ☐ Yes
- ☐ No
- ☐ Does not apply

Have you had a colorectal cancer screening or colonoscopy?

- ☐ Yes
- ☐ No
- ☐ Does not apply

Have you had your annual physical?

- [ ] Yes
- [ ] No

Have you had a flu shot in the past year?

- [ ] Yes
- [ ] No

Have you had a COVID-19 shot?

- [ ] Yes
- [ ] No

If yes, have you had a COVID-19 booster in the past year?

- [ ] Yes
- [ ] No
- [ ] Not sure

Are you deaf, or do you have hearing loss that requires special equipment?

- [ ] Yes
- [ ] No

Have you had an eye exam in the past 12 months?

- [ ] Yes
- [ ] No

Have you seen a dentist in the past 12 months?

- [ ] Yes
- [ ] No

How many days per week do you participate in physical activity, even for short periods of time? Examples would be a brisk walk, running, exercise or gym activities, or a sports program.

- [ ] None
- [ ] 1 – 2 days
- [ ] 3 – 4 days
- [ ] 5 – 7 days

How many hours of sleep do you usually get per night?

- [ ] Less than 6 hours
- [ ] 6 – 7 hours
- [ ] More than 7 hours

In general, how would you rate the current level of stress in your life?

- [ ] Low
- [ ] Medium
- [ ] High

Do you eat fruits and vegetables daily?

- ☐ Yes
- ☐ No
- ☐ Do not like
- ☐ Cannot get

In the past 12 months, have you had to worry if the food in your house would run out before there was money to get more?

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

In the past two months, have you been living in secure housing that you own, rent or stay in as part of a family group?

- ☐ Yes
- ☐ No

Do you have any of the following health conditions right now? Check all that apply.

- ☐ Alcohol or drug use
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune disease
- ☐ Blindness
- ☐ Cancer
- ☐ Chronic pain
- ☐ Cognitive impairment
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Cystic fibrosis
- ☐ Depression
- ☐ Dementia or Alzheimer's disease
- ☐ Developmental delay
- ☐ Diabetes
- ☐ End-stage renal disease
- ☐ Gastrointestinal issues
- ☐ Heart disease
- ☐ Heart failure
- ☐ Hemophilia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV or AIDS
- ☐ Kidney disease/failure
- ☐ Learning disability
- ☐ Liver disease
- ☐ Neurological disorders
- ☐ Sickle cell anemia
- ☐ Speech impairment
- ☐ Tobacco or vaping use
- ☐ Visual impairment
- ☐ Wound care
- ☐ Other: _____
- ☐ None

Do you use any of the following medical equipment?

- ☐ Cane/walker/crutches
- ☐ Wheelchair
- ☐ Limb braces or prosthetics
- ☐ Contacts or glasses

- [ ] Diabetic supplies/equipment
- [ ] Hearing aids
- [ ] Nebulizer
- [ ] Oxygen
- [ ] CPAP/Bi-PAP
- [ ] Other: _____

Are you having any trouble taking medications given by your doctor? Check all that apply.

- [ ] None given
- [ ] No problems
- [ ] Do not understand enough about the medications
- [ ] Medication has side effects
- [ ] Allergic to medications given
- [ ] Swallowing problems
- [ ] Too difficult to take
- [ ] Forget to take
- [ ] Have doctor or pharmacy issues
- [ ] Cannot afford copays
- [ ] Insurance coverage questions or problems
- [ ] No transportation to get medication
- [ ] Don't need medication anymore
- [ ] Ran out or did not refill or tried to fill too early

Over the past two weeks, how often have you been bothered by having little interest or pleasure doing things?

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

Over the past two weeks, how often have you been bothered by feeling down, depressed or hopeless?

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

Over the past two weeks, how often have you been bothered by feeling nervous, anxious or on edge?

- [ ] Not at all
- [ ] Several days

☐ More than half the days
☐ Nearly every day

Over the past two weeks, how often have you been bothered by not being able to stop or control worrying?

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

Are you currently involved in counseling or therapy for depression or anxiety?

☐ Yes
☐ No
☐ Would like assistance