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 your child 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

Is your child Hispanic or Latino?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

What is your child's race?

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

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

What is your child's age?

- [ ] Under 1 year
- [ ] 1 – 6 years
- [ ] 7 – 13 years
- [ ] 14 – 17 years

Who is completing this form? What is your relationship to the child?

- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Guardian
- [ ] Self
- [ ] Other

What sex was your child given at birth on his or her original birth certificate?

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

What gender does your child 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
- [ ] Don't know

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

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

In what language are you most comfortable reading and speaking?

- ☐ English
- ☐ Spanish
- ☐ Other

How tall is your child without shoes (in inches)? _____

How much does your child weigh (in pounds)? _____

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

In general, how is your child's health?

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

Does your child 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 child's 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.

Has your child had his or her annual wellness checkup?

- ☐ Yes
- ☐ No
- ☐ Not sure

Is your child up to date with his or her immunizations (shots)?

- ☐ Yes
- ☐ No
- ☐ Not sure

Has your child had a lead poisoning test?

- ☐ Yes
- ☐ No
- ☐ Not sure

Has your child had a flu shot within the last year?

- ☐ Yes
- ☐ No
- ☐ Not sure

Has your child had a COVID-19 shot?

- ☐ Yes
- ☐ No
- ☐ Not sure

If yes, has your child had a COVID-19 booster in the past year?

- ☐ Yes
- ☐ No
- ☐ Not sure

Has your child had the human papillomavirus (HPV) vaccine?

- ☐ Yes
- ☐ No
- ☐ Not sure

Is your child currently pregnant?

- ☐ Yes
- ☐ No
- ☐ Not sure

Is your child deaf, or does he or she have hearing loss that requires special equipment?

- ☐ Yes
- ☐ No

Has your child had an eye exam in the past 12 months?

- ☐ Yes
- ☐ No
- ☐ Not sure

Has your child seen a dentist in the past 12 months?

- ☐ Yes
- ☐ No
- ☐ Not sure

Does your child 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.

- ☐ Yes
- ☐ No
- ☐ Not sure

How many hours of sleep does your child usually get in a day, including naps?

- ☐ Less than 8 hours
- ☐ 8 – 11 hours
- ☐ 12 – 16 hours
- ☐ More than 16 hours

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

- ☐ Low
- ☐ Medium
- ☐ High

Does your child eat fruits and vegetables daily?

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

Within 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

Does your child have any of the following health conditions right now? Check all that apply.

- ☐ Attention-deficit disorder (ADD) or attention-deficit hyperactivity disorder (ADHD)
- ☐ Alcohol or drug use
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune disease
- ☐ Blindness
- ☐ Cancer or leukemia
- ☐ Cerebral palsy
- ☐ Congenital heart defect
- ☐ Cystic fibrosis
- ☐ Depression
- ☐ Developmental delay
- ☐ Diabetes
- ☐ Gastrointestinal issues
- ☐ Growth hormone deficiency
- ☐ Hemophilia
- ☐ High cholesterol
- ☐ HIV or AIDS
- ☐ Kidney disease/failure
- ☐ Learning disability
- ☐ Liver disease
- ☐ Muscular dystrophy
- ☐ Respiratory distress/disease
- ☐ Sickle cell anemia
- ☐ Speech impairment
- ☐ Tobacco or vaping use
- ☐ Visual impairment
- ☐ Wound care
- ☐ Other: _____
- ☐ None

Does your child use any of the following medical equipment?

- ☐ Walker/crutches
- ☐ Wheelchair
- ☐ Limb braces or prosthetics
- ☐ Contacts or glasses
- ☐ Diabetic supplies/equipment
- ☐ Hearing aids
- ☐ Nebulizer
- ☐ Oxygen
- ☐ CPAP/Bi-PAP
- ☐ Home ventilator
- ☐ Home monitor
- ☐ Feeding pump
- ☐ Other: _____

Does your child struggle to take medications given by his or her doctor? Check all that apply.

- [ ] None given
- [ ] No problems
- [ ] Do not understand enough about the medications
- [ ] 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 noticed your child 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 noticed your child 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 noticed your child 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 noticed your child not being able to stop or control worrying?

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

Does your child currently see a therapist for depression or anxiety?

- ☐ Yes
- ☐ No
- ☐ Would like assistance

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