Medicare Health Survey

Please complete and return in the envelope provided. You can also go to www.cdphp.com/medicarehealthsurvey to take the survey online.

A plan for life.

Name: ____________________

Address: ____________________

City, State, ZIP Code: ____________________

Date of Birth: ____________ Member ID # *(located on ID card)*: ____________

Mobile Phone #: ____________ Home or Landline #: ____________

I would like to receive text messages from CDPHP: ☐ Yes ☐ No

Email address: ____________________

By providing your email address here, you are consenting to receive emails from CDPHP.

General and Preventive Care:

- In general, would you say your health is:
  ☐ Excellent ☐ Good ☐ Fair ☐ Poor
- Have you had a flu shot this year or are you planning to receive one this year? .... ☐ Yes ☐ No
- Have you had a pneumonia shot once in the last five years? .... ☐ Yes ☐ No
- Have you received the COVID-19 vaccine? .... ☐ Yes ☐ No

Health Conditions:

- Do you have a primary care doctor? .... ☐ Yes ☐ No
- Have you been seen by your doctor in the last year? .... ☐ Yes ☐ No
- Are you behind on regularly scheduled preventive health care such as cancer screenings or immunizations? .... ☐ Yes ☐ No
- In the past three months, have you received care from...
  A telemedicine provider (through a phone call or video)? .... ☐ Yes ☐ No
  An urgent care facility? .... ☐ Yes ☐ No
  An emergency room? .... ☐ Yes ☐ No
  A hospital? .... ☐ Yes ☐ No
- Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, who specialize in one area of health care. Is your personal doctor a specialist? .... ☐ Yes ☐ No

If you need help finding a doctor or other provider, please call Member Services at 1-888-248-6522.

- What health or medical conditions do you have now or have had in the past? ***(check all that apply):***
  ☐ anxiety ☐ asthma ☐ bi-polar disorder
  ☐ cancer ☐ COPD/emphysema ☐ dialysis
  ☐ dementia ☐ depression ☐ diabetes
  ☐ hearing problems ☐ heart disease ☐ hypertension (high blood pressure)
  ☐ organ transplant ☐ schizophrenia ☐ stroke
  ☐ vision problems ☐ kidney disease ☐ not applicable
  ☐ Other: ____________________
- Do you have a history of falls or problems with balance? .... ☐ Yes ☐ No
- Do you currently use any assistive device(s) such as a walker, cane, wheelchair, commode, oxygen? .... ☐ Yes ☐ No

(Continued on other side)

(Continued from other side)

- How many **prescription or over-the-counter medications** do you take on a regular basis?

  ☐ 0 ☐ 1–2 ☐ 3–5 ☐ 6–8 ☐ 9 or more

- If you are prescribed medications for diabetes, high cholesterol, or high blood pressure, how would you describe the way you take them?

  ☐ I always take my medications as prescribed

  ☐ I sometimes take my prescription medications as prescribed

  ☐ I seldom take my prescription medications as prescribed

  ☐ I can't afford my medications and usually don't fill my prescriptions

  ☐ I don't take my prescriptions as prescribed for another reason

  ☐ Not applicable

- What is the biggest obstacle for taking care of yourself?

  ☐ Housing ☐ Food ☐ Utilities

  ☐ Transportation ☐ None ☐ Other: ________________

- Do you need any assistance with scheduling a medical appointment or understanding your health insurance benefits? .... ☐ Yes ☐ No

- Do you live *(check one answer)*:

  ☐ Alone ☐ With spouse ☐ With a son or daughter

  ☐ With other family member ☐ Other ______________________________

- Do you live in:

  ☐ Your own home, apartment, condominium, or mobile home?

  ☐ An assisted living apartment, nursing home, or adult care facility?

- In the past four weeks, have you experienced a feeling of depression, hopelessness, or loss of interest in pleasurable activities? .... ☐ Yes ☐ No

- Do you have difficulty remembering events that have happened in the recent past? . ☐ Yes ☐ No

- During the last 12 months, have you used alcohol or drugs in ways that cause problems for you or those around you? .... ☐ Yes ☐ No

- Do you smoke tobacco or use nicotine products? .... ☐ Yes ☐ No

About You:

- Have you signed any of the following legal documents:

  Power of Attorney .... ☐ Yes ☐ No Living Will.................. ☐ Yes ☐ No

  Do Not Resuscitate Order (DNR) ☐ Yes ☐ No Health Care Proxy .... ☐ Yes ☐ No

  MOLST (Medical Order for Life-Sustaining Training) .... ☐ Yes ☐ No

I, ____, hereby authorize CDPHP® to make all of the information in this questionnaire available to my physician for case management purposes. This authorization shall remain in effect until revoked by me in writing, and may be revoked at any time except to the extent that CDPHP has already acted in reliance upon it. (References to "CDPHP" refer to both Capital District Physicians' Health Plan, Inc. and CDPHP Universal Benefits,® Inc.)

Dated: ______________________________

______________________________ ______________________________

Signature Print Name

______________________________ ______________________________

Agent Name (optional) Agent ID (optional)