Health Risk Assessment

Your Name (First, Middle and Last Name)			Date of Birth (mm/dd/yyyy)
Home Address		Apartment Number	**mihealth** ID Number
City, State and Zip Code			Meridian Member ID Number
Home Phone Number	Cell Phone Number	Email Address	Best way to contact you? ☐ Home Phone ☐ Cell Phone ☐ Email

SECTION 1 - Initial assessment questions (check one for each question)

1. **In general, how would you rate your health?** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. **In the last 7 days, how often did you exercise for at least 20 minutes in a day?**
   ☐ Every day ☐ 3-6 days ☐ 1-2 days ☐ 0 days

Exercise includes walking, housekeeping, jogging, weights, a sport or playing with your kids. It can be done on the job, around the house, just for fun or as a work-out.

3. **In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day?**
   ☐ Every day ☐ 3-6 days ☐ 1-2 days ☐ 0 days

Each time you ate a fruit or vegetable counts as one serving. It can be fresh, frozen, canned, cooked or mixed with other foods.

4. **In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time?** ☐ Never ☐ Once a week ☐ 2-3 times a week ☐ More than 3 times during the week

1 drink = 1 beer, 1 glass of wine, or 1 shot.

5. **In the last 30 days have you smoked or used tobacco?** ☐ Yes ☐ No

   If YES, Do you want to quit smoking or using tobacco?
   ☐ Yes ☐ I am working on quitting or cutting back right now ☐ No

6. **In the last 30 days, how often have you felt tense, anxious or depressed?**
   ☐ Almost every day ☐ Sometimes ☐ Rarely ☐ Never

7. **Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax?** ☐ Almost every day ☐ Sometimes ☐ Rarely ☐ Never

This includes illegal or street drugs and medications from a doctor or drug store if you are taking them differently than exactly how your doctor told you to take them.

8. **The flu vaccine can be a shot in the arm or a spray in the nose. Have you had a flu shot or flu spray in the last year?** ☐ Yes ☐ No

9. **A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last checkup?** ☐ Within the last year ☐ Between 1-3 years ☐ More than 3 years

Take this form to your check-up and complete the rest of the form with your doctor at this appointment.

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

SECTION 2 - Annual appointment

A routine checkup is an important part of taking care of your health. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan and your health plan can help you with a ride to and from this appointment.

What month did you first schedule this appointment? _____
(Month)

Date of appointment: _____
(mm/dd/yyyy)

At my appointment, I would most like to talk with my doctor about:

_____

An annual appointment gives you a chance to talk to your doctor and ask any questions you may have about your health including questions about medications or tests you might need.

Section 3 - Readiness to change

Your Healthy Behavior

Small everyday changes can have a big impact on your health. Think about the changes you would be most interested in making over the next year**.** Look at the list below and **CHOOSE ONE or MORE**:

☐ Exercise regularly, eat better, and/or lose weight	☐ Cut back or quit drinking alcohol
☐ Cut back or quit smoking or using tobacco	☐ Seek treatment for drug or substance abuse
☐ Get a flu shot	☐ I will commit to keep up all of the healthy things I do now
☐Return to the doctor to get tested for high blood pressure, high cholesterol and diabetes OR if I already have any of them, return to the doctor for check-ups for these conditions	☐ Other:

Changes like drinking water rather than soda or walking every day can help you stay healthy or help you better control illnesses you may already have. You can learn new ways to handle stress or quit smoking. Remember, even small changes can be difficult and take a long time. It may be helpful to get support from your family, friends, community or your doctor. Your health plan may have programs that can help you.

Now that you have selected your healthy behavior(s) above, answer questions 1 - 3. For each question, use the scale provided and pick a number from 0 through 5.

1. Thinking about your healthy behavior(s), do you want to make some small lifestyle changes in this area to improve your health?

☐ **0** I don't want to make changes now
☐ **1**
☐ **2**
☐ **3** I want to learn more about changes I can make
☐ **4**
☐ **5** Yes, I know the changes I want to start making

2. How much support do you think you would get from family or friends if they knew you were trying to make some changes?

☐ **0** I don't think family or friends would help me
☐ **1**
☐ **2** I think I have some support
☐ **3**
☐ **4**
☐ **5** Yes, I think family or friends would help me

3. How much support would you like from your doctor or your health plan to make these changes?

☐ **0** I do not want to be contacted
☐ **1**
☐ **2** I want to learn more about programs that can help me
☐ **3**
☐ **4**
☐ **5** Yes, I am interested in signing up for programs that can help me

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

Section 4 – To be completed by your primary care provider

Primary care providers – please fill out this section in its entirety for Meridian Healthy Michigan Plan members. Select a healthy behavior statement in discussion with the member. Complete this form by signing at the bottom as your attestation of the healthy behavior and the appointment. All three parts of Section 4 must be filled in for the attestation to be considered complete.

Member Results			
Blood Pressure	_____ (xxx/xxx mHg)	Patient diagnosed with hypertension? ☐Yes ☐No	
BMI	Height _____ Weight _____ BMI _____ (xx.x)	In the context of all relevant clinical factors, does this BMI indicate need for weight management? ☐Yes ☐No	
Tobacco Use Status	☐Never used tobacco ☐Previous tobacco user ☐Current tobacco cessation ☐Starting tobacco cessation ☐Tobacco user		
Cholesterol	Cholesterol known? ☐Yes ☐No	Patient diagnosed with high cholesterol? ☐Yes ☐No	
	If cholesterol known is **Yes**: Total cholesterol: _____ Date of most recent test results: _____	LDL:	
	If cholesterol known is **No**: ☐Screening not recommended ☐Screening ordered	HDL: Triglycerides:	
Blood Sugar	Blood sugar known? ☐Yes ☐No	Patient diagnosed with diabetes? ☐Yes ☐No	
	If blood sugar known is **Yes**: Date of most recent test results: _____	FBS (xxx mg/dl): A1C (xx.x%)	
	If blood sugar known is **No**: ☐Screening not recommended ☐Screening ordered		
Influenza Vaccine	Annual Influenza Vaccination? ☐Yes ☐No		
	If Influenza vaccination is **Yes**: Date of most recent vaccination: _____	If Influenza vaccination is **No**: ☐Vaccination not recommended ☐Vaccination recommended	

Healthy Behaviors - Choose one of the following statements (**1** - **4**).

☐ **1. Patient does not have health risk behaviors that need to be addressed at this time.**

☐ **2. Patient has identified at least one behavior to address over the next year to improve their health. Choose one or more:**

- ☐ **Increase physical activity, learn more about nutrition and improve diet, and/or weight loss**
- ☐ **Reduce/quit tobacco use**
- ☐ **Annual influenza vaccine**
- ☐ **Agrees to follow-up appointment for screening or management of hypertension, cholesterol and/or diabetes**
- ☐ **Reduce/quit alcohol consumption**
- ☐ **Treatment for Substance Use Disorder**
- ☐ **Other: explain** _____

☐ **3. Patient has a serious medical, behavioral or social condition(s) that prevents addressing unhealthy behaviors at this time.**

☐ **4. Unhealthy behaviors have been identified; patient's readiness to change has been assessed. Patient is not ready to make changes at this time.**

I attest that I have examined the member named above and the information is complete and accurate to the best of my knowledge. I have provided a copy of this Health Risk Assessment to the member.

Print Name (First Name, Last Name)	**National Provider Identifier** (NPI)
Signature	**Date**

Submission: Submit completed forms securely by fax to the Meridian Quality Improvement department at 313-324-9120.