Aetna Better Health® of Illinois

Health Risk Screening - Adult

Please take a few minutes to fill out this form. This will help us identify any extra needs or services you may need. Place this completed form in the provided postage paid envelope and drop it in the mail. If you have any questions, call Member Services at **1-866-329-4701 (TTY: 711)**.

Name:_____ Date of Birth: _____ Medicaid ID#:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone #:_____ Cell #:_____ ☐ No Phone

Email:_____

Q#	Question/Selections
1	**How well do you speak English?** ☐ Not at all ☐ Not well ☐ Well ☐ Very well
2	**Do you have a doctor/primary care provider (PCP) or clinic you go to when you are sick?** ☐ Yes, only one (list name in Comments) ☐ More than one (list names in Comments) ☐ No, I do not have one **Comments:** _____
3	**Does your doctor or clinic give you pills or medicine you have to take every day?** ☐ Yes ☐ No
4	**Have you stopped taking any pills or medicine and NOT told your doctor?** ☐ Yes ☐ No
5	**Do you have problems with your teeth or gums?** ☐ Yes ☐ No
6	**Do you need help finding a dentist?** ☐ Yes ☐ No
7	**Would you say that in general your health is … :** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
8	**In the last month, how many days did you feel so bad that you could not work, take care of yourself, or have fun?** Number of days ____
9	**In the last month, how many days were you sad, stressed, down, or had problems with bad feelings?** Number of days ____

Q#	Question/Selections
10	**Have you gone to a doctor or clinic for mood or stress problems or for drug or alcohol problems?** ☐ Yes ☐ No
11	**Do you think you need to?** ☐ Yes ☐ No
12	**How many times in the last month did you have more than 4-5 drinks (alcohol) at once?** Number of times ____
13	**A doctor or clinic told me I have this: (check all that apply to you)** ☐ Currently pregnant ☐ ADHD – Attention or learning problems ☐ Breathing problems ☐ Blood pressure problems ☐ Alcohol or drug use ☐ Anxiety ☐ Asthma ☐ Bone or joint problems like arthritis, amputation, chronic low back pain, missing limbs ☐ Bowel or stomach problems like ulcers, chronic diarrhea, Crohn's disease ☐ Coronary Artery Disease (CAD)- disease of the blood vessels to the heart ☐ Cancer ☐ COPD (lung disease) ☐ Depression ☐ Diabetes ☐ Hearing problems like deafness, hearing aids ☐ Heart problems like chest pain, heart attacks, heart failure ☐ High Cholesterol (Hyperlipidemia) ☐ Hypertension (High Blood Pressure) ☐ Infection problems like Hepatitis, HIV/AIDS or TB ☐ Kidney problems like dialysis ☐ Mental health problems like depression ☐ Nerve or brain problems like: stroke, Multiple Sclerosis, spinal cord or brain injury ☐ Overweight or Obesity ☐ Vision problems like cataracts, blindness ☐ Transplant (tell us what type in Comments) ☐ Weight management ☐ Other (List in Comments) **Comments:** _____ _____

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Q#	Question/Selections
14	**On a scale of 1-10 with 1 = Absolutely no control and 10 = LARGE amount of control, Do you feel you have any control over your health problems or illnesses?** Circle amount of control: ☐1☐2☐3☐4☐ 5☐6☐7☐8☐9 ☐10
15	**In the last 3 months, it is harder for me to move and get around:** ☐ Yes ☐ No
16	**In the last 3 months, it is harder for me to speak, think or remember things:** ☐ Yes ☐ No
17	**In the last 6 months, did you go to the emergency room or stay the night in the hospital more than two times?** ☐ Yes ☐ No
18	**How many different addresses have you had in the last 12 months?** ☐ Only 1 address in last year ☐ 2-3 addresses ☐ More than 3 I am homeless or sleep in a shelter right now
19	**In the last 6 months, did you (or the member) stay the night at the hospital for <u>something you or your doctor DID NOT PLAN?</u> (because you got sicker or got really hurt)?** ☐ Yes ☐ No
20	**Do you use tobacco products (cigarettes, smokeless tobacco like chew or vaping)?** ☐ Yes – doesn't want to quit or reduce ☐ Yes – would like to quit or reduce ☐ No