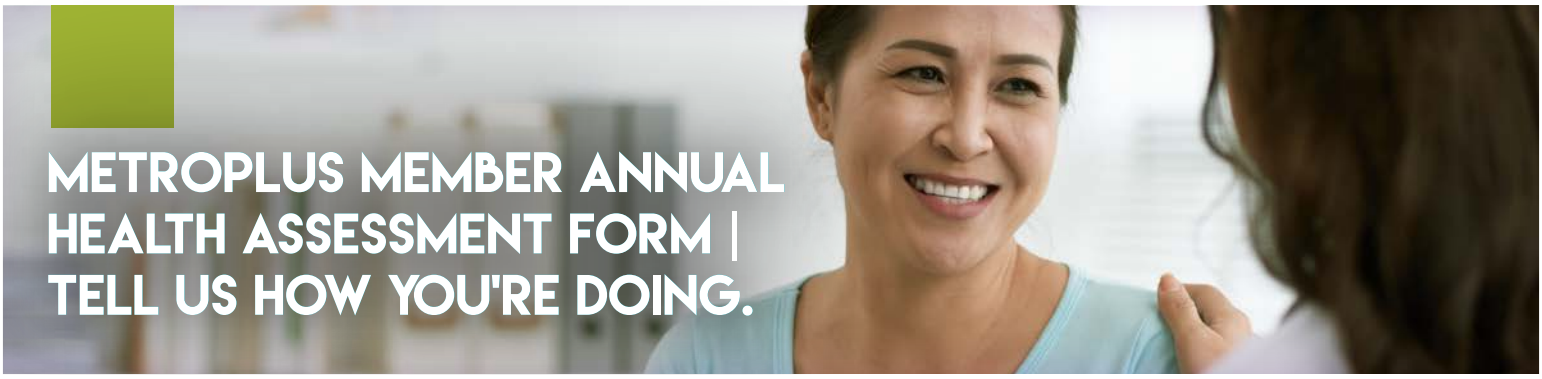


METROPLUS MEMBER ANNUAL HEALTH ASSESSMENT FORM | TELL US HOW YOU'RE DOING.

Please complete this form and mail it back to:
MetroPlus Health Plan • 160 Water Street, 3rd Fl. • New York, NY 10038

First, Last Name: _____ **Member ID#:** _____

Mailing Address: _____

Phone: _____ Date of Birth: _____ Height: _____ft. _____ in. Weight: _____lbs. BMI: _____

Preferred Language: ❑ English ❑ Spanish ❑ Chinese ❑ Creole ❑ Urdu ❑ Bengali ❑ Other: _____

Would you like us to call you to help you with a health problem? ❑ Yes ❑ No

In general, would you say that your health is: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you have a doctor you see regularly? ❑ Yes ❑ No

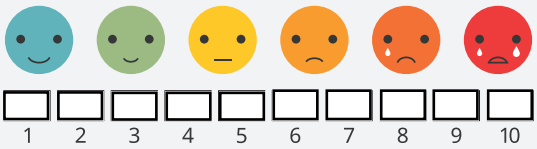
Do you have any of the following? ❑ Diabetes ❑ Heart problems ❑ High blood pressure ❑ Cancer
❑ Breathing problems (asthma or COPD) ❑ Memory problems ❑ Hearing problems ❑ Vision problems
❑ Mental problems ❑ Drug or alcohol problems ❑ Other medical problems: _____

How many different medicines do you take a day? ❑ None ❑ 1-3 ❑ 4-7 ❑ 8 or more

Do you have repeated or ongoing pain?

❑ Yes ❑ No **If yes,** start date: _____ **If yes,** where is the pain? _____

If yes, mark off your level of pain here:



Do you need help with your basic activities (such as getting dressed, taking a bath, eating, getting in / out of a chair)?
❑ I'm able to do this without help ❑ I need help, and get the help I need ❑ I need help, and do not get the help I need

Do you need help with housekeeping, taking medication, shopping, money management, or transportation?
❑ I'm able to do this without help ❑ I need help, and get the help I need ❑ I need help, and do not get the help I need

Did you fall in the past 6 months? ❑ Yes ❑ No

Do you use any of the following: ❑ Cane ❑ Walker ❑ Wheelchair ❑ Hospital bed ❑ Oxygen
❑ Other _____

Do you live in: ❑ A home with family / friends
❑ A home alone ❑ A shelter ❑ I'm homeless

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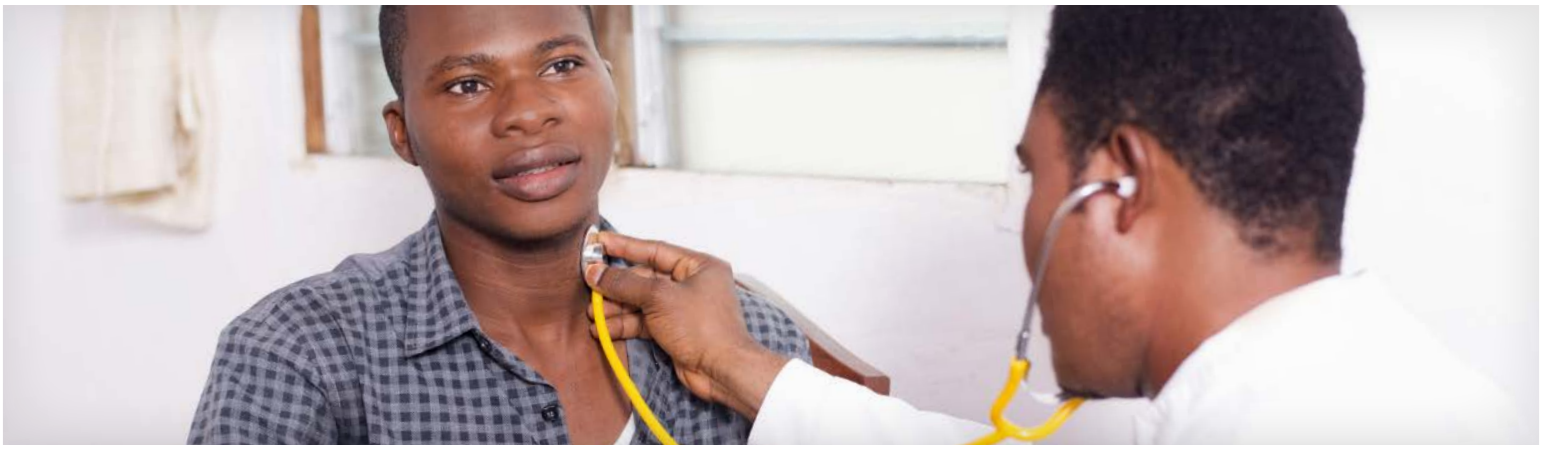

Do you currently receive public assistance (Food Stamps, Meals on Wheels, ADAP, EPIC, etc.)?

❑ Yes ❑ No ❑ I do not know

Do you smoke cigarettes or use tobacco: ❑ Yes ❑ No

Did you have the Influenza Vaccine (Flu Shot) this year? ❑ Yes ❑ No ❑ I'm allergic ❑ I do not know

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Over the past 2 weeks, how often have you had little interest or pleasure in doing things?

❑ Not at all ❑ Several Days ❑ More than half of the days ❑ Almost every day

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

❑ Not at all ❑ Several Days ❑ More than half of the days ❑ Almost every day

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ONLY WOMEN 50 YEARS OLD AND UNDER: Are you pregnant? ❑ Yes ❑ No ❑ I do not know

ONLY WOMEN 50-74 YEARS OLD: Did you have a mammogram (to check for breast cancer) this year or last?

❑ Yes ❑ No ❑ I do not know

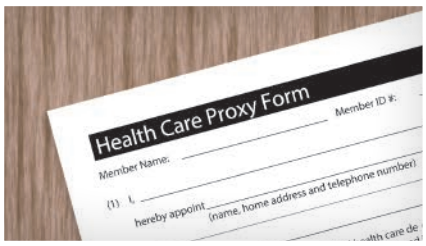
ONLY THOSE 50-75 YEARS OLD: Did you have the following tests to check for colon cancer?

❑ Colonoscopy (in the past 10 yrs.) ❑ Sigmoidoscopy (in the past 5 yrs.) ❑ Stool Test for blood (within the last yr.)

Do you have any of the following?

- ❑ **Advance Directive / Living Will (a document that says what medical treatment you would like if you are unable to speak for yourself)**
- ❑ **Health Care Proxy (a person who can make health care decisions for you, if you are not able to)**
- ❑ **No, but advanced care planning was discussed with me**
- ❑ **No, and advanced care planning was not discussed with me**
- ❑ **No, but I am interested to learn more:** ❑ Yes* ❑ No

* We will send you an Advance Directive and Health Care Proxy Form.



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