Health Survey

Thank you in advance for completing Lasso Healthcare's health survey. It should take between 10 and 15 minutes to complete. Please return your completed survey, along with your completed health survey reward request form, in one of the provided envelopes.

IMPORTANT: Please print clearly in ink.

Your Identity Basics *Please confirm some basic information about yourself.*

Member/Patient Name ______________________________

Member ID # ____________________ DOB ____/____/________

Gender ○ Male ○ Female Height __ ft _____ in Weight ________ lbs

Name of Primary Provider ______________________________

Name(s) of Specialist(s) ______________________________

Your Hospitalization History

Have you been to the ER within the last year? ○ Yes ○ No

If Yes, when? ____/____/________

If Yes, for what? ______________________________

Have you been admitted to the hospital overnight, within the last year, for any medical or surgical condition or an accident? ○ Yes ○ No

If Yes, for what? ______________________________

Your Medications and Supplements

Are you currently taking any prescription medications? ○ Yes ○ No If so, how many? _____

Are you taking any non-prescription medications or supplements? ○ Yes ○ No If so, how many? _____

Your Chronic Conditions *Help us better understand any chronic conditions you may have.*

Diabetes

Have you ever been diagnosed with Diabetes? ◯ Yes ◯ No (if "No", skip to next section)

Were you diagnosed with Type 1 or Type 2? ◯ Type 1 ◯ Type 2 ◯ Don't know

If so, when? ______ / ______ / ______

Have you had complications? ◯ Yes ◯ No

If so, please describe the complications: ______________________

Do you self-manage (e.g., glucose tests, exercise, etc.)? ◯ Yes ◯ No

Do you see your provider regularly? ◯ Yes ◯ No

Did you have a lab test during the past year that tested your A1C levels? ◯ Yes ◯ No

Have you had an eye exam during the past year? ◯ Yes ◯ No

Have you had a kidney function test during the past year? ◯ Yes ◯ No

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High Blood Pressure

Have you ever been diagnosed with, or do you currently have, high blood pressure? ◯ Yes ◯ No (if "No", skip to next section)

Did you receive treatment or medication for your blood pressure during the last calendar year? ◯ Yes ◯ No

What was your blood pressure when last checked by your provider? If you don't remember, what was it the last time you checked? ______ / ______

Heart

Have you been diagnosed with a heart condition, such as: Irregular Heartbeat (i.e., atrial fibrillation or AFIB), Angina (e.g., chest pain with exercise), Heart Attack or Heart Failure (HF)? ◯ Yes ◯ No (if "No", skip to next section)

Are you under the care of a provider for any of these conditions? ◯ Yes ◯ No

Your Chronic Conditions, continued ...

Lung

Have you ever been diagnosed with, or do you currently have, a chronic lung condition (respiratory) such as Chronic Obstructive Pulmonary Disease (COPD)? ◯ Yes ◯ No (if "No", skip to next section)

Have you had any serious lung conditions, such as pneumonia or asthma? ◯ Yes ◯ No

Are you under the care of a provider for any of these conditions? ◯ Yes ◯ No

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Kidneys

Have you ever been diagnosed with, or do you currently have, a serious kidney condition, such as kidney failure (nephropathy) or other condition? ◯ Yes ◯ No (if "No", skip to next section)

Are you on dialysis? ◯ Yes ◯ No

Liver

Have you ever been diagnosed with, or do you currently have a liver problem, such as hepatitis or cirrhosis? ◯ Yes ◯ No (if "No", skip to next section)

Are you under the care of a provider for any of these conditions? ◯ Yes ◯ No

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Cancer

Have you ever been diagnosed with, or do you currently have, cancer? ◯ Yes ◯ No (if "No", skip to next section)

What type of cancer were you diagnosed with? ______________________

Are you currently being treated? ◯ Yes ◯ No

Rheumatologic/Musculoskeletal

Have you ever been diagnosed with, or do you currently have, rheumatoid arthritis, Lupus or other arthritic conditions? ◯ Yes ◯ No (if "No", skip to next section)

Were you issued one or more prescriptions for an anti-rheumatic drug? ◯ Yes ◯ No

Your Chronic Conditions, continued ...

Mental Health Disorders

Question	Response
Have you ever been diagnosed with a serious mental illness, such as depression, bipolar disorder or schizophrenia?	◯ Yes ◯ No (if "No", skip to next section)
Are you on medication?	◯ Yes ◯ No

Lifestyle Profile *Help us build a profile of your personal lifestyle habits that may impact your health.*

Question	Response
Do you smoke?	◯ Yes ◯ No (if "No", skip to next question)
Are you interested in quitting?	◯ Yes ◯ No
Do you drink alcohol?	◯ Yes ◯ No (if "No", skip to next question)
How many drinks do you consume, on average, per week? (A typical drink is 12 oz. of regular beer, 5 oz of wine or 1.5 oz of distilled spirits; e.g., gin, rum, tequila, vodka, whiskey, etc.)	◯ < 3 ◯ 4 - 7 ◯ > 7
Have you taken any opioid or narcotics, prescribed or unprescribed, in the last year?	◯ Yes ◯ No

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Preventive Activities *Describe the key things you do to help maintain your health.*

Question	Response
Do you exercise?	◯ Yes ◯ No
In the past year, have you discussed exercise with your provider and did he/she advise you to start, increase, or maintain your physical activity during the year?	◯ Yes ◯ No
Do you have an annual routine physical with your provider?	◯ Always ◯ Most Years ◯ Sometimes ◯ Rarely ◯ Never
If applicable, do you regularly have mammograms to screen for breast cancer?	◯ Regularly ◯ Occasionally ◯ Never
How many years ago did you have your last mammogram?	______ Years ago
If applicable, when was the last time you had a prostate screening?	______ Years ago

Preventive Activities, continued ...

Have you ever had a colonoscopy?	◯ Yes ◯ No
Have you discussed how and how often you should receive regular colonoscopies with your provider?	◯ Yes ◯ No
When was the last time you had a bone density screening (i.e., a bone mass measurement)?	______ Years ago
Have you had a problem falling, walking, or balancing over the past year?	◯ Yes ◯ No (if "No", skip next question)
Did you discuss it with your provider and did they provide a recommendation for how to prevent falls during the year?	◯ Yes ◯ No