



## ADULT HEALTH INFORMATION

### AGE 20 AND OVER

Please help your doctor and Samaritan Select by answering the following questions about your health. The information you provide will enable us to better serve your health care needs. **All information given in this form will be kept confidential and will not affect your benefits in any way.** After receiving this information, your doctor or a Samaritan Select nurse case manager may contact you. If you have any questions, please contact us at (541) 768-6900 or 1-800-569-4616.

Name: \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ Birth Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ (feet) \_\_\_\_\_ (inches) Weight: \_\_\_\_\_ (lbs) Blood Pressure (if you know it): \_\_\_\_\_

Write the name of your chosen medical home provider: \_\_\_\_\_

- (1) For your age, how is your health?
  - a. Very good
  - b. Good
  - c. Not good
- (2) Compared to one year ago, would you say that your health is:
  - a. Better
  - b. The same
  - c. Worse
- (3) My diet is:
  - a. Very healthy
  - b. Okay
  - c. Not healthy
- (4) How physically active are you?
  - a. Very
  - b. Somewhat
  - c. Not at all
- (5) Have you ever been exposed to any of the following?  
Circle all that apply.
  - a. Repetitive movements
  - b. Asbestos
  - c. Long periods of time in the sun
  - d. Chemicals
- (6) Do you currently use tobacco products?
  - a. Yes, I smoke cigarettes.
  - b. Yes, I smoke cigars or a pipe.
  - c. Yes, I chew tobacco.
  - d. No, I do not use tobacco.
- (7) Do you live or work in a smoky environment?  
 Yes  No
- (8) Do you use any street drugs?  
 Yes  No
- (9) During the past six months, have your work or social activities been limited due to a problem with your physical health?  
 Yes  No

(10) In the past six months, have you often felt stressed-out or depressed?

Yes  No

(11) In the past six months have you lost more than 10 pounds without trying?

Yes  No

(12) Have you had any major lifestyle changes in the last 6 months?

Yes  No

If yes, list: \_\_\_\_\_

(13) Do you have any disabilities or special medical equipment needs (oxygen tank, wheel chair, etc.)?

Yes  No

If yes, list: \_\_\_\_\_

(14) How many times have you seen your doctor in the past year? \_\_\_\_\_

(15) How many times have you been admitted to a hospital in the past year? \_\_\_\_\_

For what? \_\_\_\_\_

(16) How many times have you been to an Emergency Room and/or Urgent Care in the past year? \_\_\_\_\_

(17) How much alcohol do you usually consume?

Per day: \_\_\_\_\_

Per week: \_\_\_\_\_

**QUESTIONS # 18 - 22 ARE FOR WOMEN ONLY**

(18) Are you pregnant?

Yes  No

If so, what is your due date? \_\_\_\_\_

(19) Are you planning on becoming pregnant within the next year?

Yes  No

(20) If you are of childbearing age and plan to get pregnant are you taking folic acid (400 mcg) in supplement form?

Yes  No

(21) Are you currently menopausal or are you going through menopause?

Yes  No

(22) Have you had a mammogram or Pap smear in the past year?

- a. Yes, I had a mammogram
- b. Yes, I had a Pap smear
- c. Yes, I had both
- d. No, neither

**QUESTION # 23 IS FOR MEN ONLY**

(23) When was your last prostate exam or PSA? \_\_\_\_\_

(24) Are you currently taking any medications (prescriptions, over-the-counter, herbal therapy, or natural remedies)?

Yes  No

If yes, please list:

Name \_\_\_\_\_ What for? \_\_\_\_\_

Name \_\_\_\_\_ What for? \_\_\_\_\_

Name \_\_\_\_\_ What for? \_\_\_\_\_

*Continue on separate page if needed.*

