



Your Health Matters

April 2, 2007

YOUR HEALTH MATTERS QUESTIONNAIRE

Ms. Mary Sample
123 Number Lane
Tampa, FL 33333

Dear Ms. Sample:

Thank you for selecting Sample Health Plan. Sample Health Plan and Primary Care Physician (PCP) would like to familiarize themselves with your health history. We are asking you to please complete the enclosed Your Health Matters Questionnaire and return it in the enclosed postage pre-paid envelope prior to your first office visit. **This information will be kept confidential by Sample Health Plan and will in no way impact your health insurance coverage.**

Even if you have already visited your PCP, this information is designed to help Sample Health Plan and your health care team meet your current health care needs as well as track your future health status. Both your physician and Sample Health Plan will receive a summary of your health information.

Please complete the questionnaire and return it as follows:

- Mail your completed form in the pre-addressed envelope provided. **Postage has been prepaid.**
- The *Your Health Matters Questionnaire* information will be forwarded directly to me.

You are not required to return this questionnaire in order to receive services. The information is designed to help your PCP and Sample Health Plan determine how care can be provided early before a condition becomes serious. This is what managed care is all about, and one way that Sample Health Plan works with you and your physician to help set the standard for quality care. If you have not already visited your PCP, we encourage you to schedule your first office visit by calling **Dr. Physician at 1-555-555-5555**. Should you have any questions regarding the questionnaire, please contact Medicare Program at 1-888-888-8888. Welcome to Sample Health Plan!

Your Health Matters Questionnaire

The following information may help Dr. Physician establish your health needs and your overall health care. Although Dr. Physician may have been your Primary Care Physician prior to your enrollment in Your Health Matters, please complete this form anyway. If you have not seen your physician recently, or if you would like to discuss the information you provided in this questionnaire, we encourage you to schedule an appointment to visit Dr. Physician for a check-up following the return of this information. **If you are experiencing serious medical symptoms which have not been discussed with your doctor please call your doctor for assistance now.** Thank you!

Please verify the accuracy of the following information, and note any corrections.

Name: Joe Sample

Address: 111 Main Street

City: Somewhere State: US Zip: 99999-9999

Phone: 999-999-9999 Date of Birth: 10/26/33

Gender: Male Height: _____ Weight: _____

Physician of record or Primary Care Physician: Dr. Primary Care Physician

Your Personal Health History

Please circle "Yes" for any condition that you now have, or, have ever had.

Yes	No	Heart Disease
Yes	No	Diabetes
Yes	No	Lung Disease
Yes	No	Stroke
Yes	No	Asthma
Yes	No	Osteoporosis
Yes	No	High Blood Pressure
Yes	No	Blood Vessel Problems
Yes	No	Cancer

Your Personal Health History (continued)

*Please circle 'Yes' for any symptoms you have experienced in the past 12 months.
Mark all that apply.*

- | | | |
|-----|----|--|
| Yes | No | Increased effort in breathing or breathlessness |
| Yes | No | Increased effort in breathing when lying down |
| Yes | No | Swelling in ankles |
| Yes | No | Chest pain |
| Yes | No | Tightness in chest |
| Yes | No | Persistent productive cough |
| Yes | No | Repeated coughing during and after exercise |
| Yes | No | Wheezing sound with breathing |
| Yes | No | Need to urinate more than one time during the night |
| Yes | No | Change in bowel habits (constipation, diarrhea, frequency) |
| Yes | No | Episodes of black or bloody stool |
| Yes | No | Excessive thirst |
| Yes | No | Unexplained weight loss |
| Yes | No | Tingling or numbness in hands or feet |
| Yes | No | Recurring / hard to heal skin or gum sores |
| Yes | No | Blurred vision |
| Yes | No | Excessive itching |
| Yes | No | History of fracture from mild fall or mild trauma |
| Yes | No | Visible, abnormal curvature of upper spine |
| Yes | No | Loss of height |
| Yes | No | Episodes of memory loss |
| Yes | No | Episodes of brief unconsciousness or dizziness |

Your Family Health History

Please circle "Yes" for any of the following conditions that a parent, a brother, or a sister has ever had.

- | | | |
|-----|----|---|
| Yes | No | Heart attack with sudden death under 50 years old |
| Yes | No | Diabetes |
| Yes | No | Lung disease |
| Yes | No | Stroke |
| Yes | No | Asthma |
| Yes | No | Mental health disorder |
| Yes | No | High blood pressure |
| Yes | No | Breast cancer |
| Yes | No | Lung cancer |
| Yes | No | Osteoporosis |

Your Social Support System

Please circle "Yes" or "No" to answer the following questions.

- | | | |
|-----|----|--|
| Yes | No | Do you live with a spouse, child, parent, or friend? |
| Yes | No | Are you the main caregiver for a parent, sibling, or child, etc.? |
| Yes | No | Do you make your own health care decisions? |
| Yes | No | Is there someone to take care of you for a few days, if necessary? |
| Yes | No | Do you have your own transportation? |
| Yes | No | If no: Can or will someone drive you to the doctor, store, etc.? |
| Yes | No | Can you take a bus or cab? |
| Yes | No | Are you able to perform activities of daily living such as walking, bathing, dressing, eating, and grooming? |

Your Recent Medical Care

Please circle the number of times during the past 12 months that you have done the following. Next, list the appropriate date. (Please include month and year.)

Visited a physician's office or medical clinic None 1 2 3 4+
Date of last: _____ / _____

Visited an emergency room or emergency clinic None 1 2 3 4+
Date of last: _____ / _____

Been admitted to a hospital None 1 2 3 4+
Date of last: _____ / _____

Had the flu or pneumonia None 1 2 3 4+
Date of last: _____ / _____

Please list the most recent date that you had the following: List month and year, or circle "Never Had" if appropriate.

Physical Exam Date of last: _____ / _____ Never Had

Flu Shot Date of last: _____ / _____ Never Had

Pneumonia Shot Date of last: _____ / _____ Never Had

Rectal Exam Date of last: _____ / _____ Never Had

Cholesterol Test Date of last: _____ / _____ Never Had

Urine Test Date of last: _____ / _____ Never Had

Glaucoma Exam Date of last: _____ / _____ Never Had

Women Only

Mammogram Date of last: _____ / _____ Never Had

Pap Smear Date of last: _____ / _____ Never Had

Thyroid Exam Date of last: _____ / _____ Never Had

General Information

Please rate your health: Excellent Very Good Good Fair Poor

Please indicate who is completing this questionnaire: (Circle One)

Member Spouse Caregiver Child Other

Please mark up to 3 health improvements you are most interested in making in the next 6 months.

- Be given tools to enhance my relationship with my doctor
- Become current with my preventive care
- Better manage my medications
- Learn to treat common ailments
- Stop or reduce tobacco use
- Improve my diet
- Attain/maintain appropriate weight
- Exercise regularly
- Handle stress better
- Improve my memory
- Reduce back pain
- Reduce arthritis discomfort
- Reduce alcohol use
- Improve my sleep
- I don't feel the need to make any improvements

I acknowledge that the information completed on this form is accurate to the best of my knowledge. I understand that my participation in this program is voluntary. I authorize **Lifestyle Management Resources, Inc.** and any representatives to share this information with appropriate members of the Medicare & More Care Network which I have selected to provide for my healthcare needs, including my Primary Care Physician, Specialists and other healthcare providers which I may be referred to, and hospital representatives. I understand that **Lifestyle Management Resources, Inc.** will treat this information in a confidential manner, and will not share it with anyone unrelated to my healthcare needs and that this information will not impact my health insurance coverage.

Signature _____ **Date** _____

If you have an E-Mail Address please provide it on the line below:

E-Mail Address _____

Guidelines for Preventive Care

19 to 39 YEARS

Primary Care Physician Office Visit

- Every one to three years

Screening

- History
- Dietary Intake
- Physical Activity
- Tobacco/alcohol/drug use
- Sexual practices

Physical Examination

- Height, weight, blood pressure

Laboratory/Diagnostic Procedures

- Total blood cholesterol
- Pap smear (every one to three years)

Immunizations

- Tetanus-diphtheria (TD) booster every 10 years

Patient Education

- Diet and Exercise
- Tobacco cessation
- Limiting alcohol consumption
- Drug Use
- Safe sexual practices
- Injury prevention: safety belts, smoke detectors
- Dental Health

40 to 64 YEARS

Primary Care Physician Office Visit

- Every one to three years

Screening

- History
- Dietary Intake
- Physical Activity
- Tobacco/alcohol/drug use
- Sexual practices

Physical Examination

- Height, weight, blood pressure
- Clinical breast examination (annually)

Laboratory/Diagnostic Procedures

- Total blood cholesterol
- Pap smear (every one to three years)
- Mammogram (very one to two years beginning at age 50, or at age 35 for those with increased risk)
- Rectal examination and/or stool for occult blood beginning at age 50

Immunizations

- Tetanus-diphtheria (TD) booster every 10 years

Patient Education

- Diet and Exercise
- Tobacco cessation
- Limiting alcohol consumption
- Drug Use
- Safe sexual practices
- Injury prevention: safety belts, smoke detectors
- Dental Health

65 YEARS AND OVER

Primary Care Physician Office Visit

- Every one to three years

Screening

- History
- Dietary Intake
- Physical Activity
- Tobacco/alcohol/drug use
- Sexual practices

Physical Examination

- Height, weight, blood pressure
- Clinical breast examination (annually)

Laboratory/Diagnostic Procedures

- Total blood cholesterol
- Pap smear (every one to three years)
- Mammogram (very one to two years beginning at age 50, or at age 35 for those with increased risk)
- Rectal examination and/or stool for occult blood beginning at age 50
- Thyroid function tests (for women)
- Glaucoma testing by an eye specialists

Immunizations

- Tetanus-diphtheria (TD) booster every 10 years
- Influenza vaccine (check with your doctor)
- Pneumococcal vaccine

Patient Education

- Diet and Exercise
- Tobacco cessation
- Limiting alcohol consumption
- Drug Use
- Safe sexual practices
- Injury prevention: safety belts, smoke detectors, prevention of falls
- Dental Health

Note: Your physician may wish to add other preventive service on a routine basis, and after considering the medical history and other individual circumstances. You should discuss any concerns with your physician.