CAREHERE HRA BIOMETRIC SCREENING QUESTIONS

TO BE COMPLETED BY STAFF					
Date of Last 411 HRA			**< 11 mos. = change 411 HRA date per patient?**	Yes	No
Confirm fasting	Yes	No	***(fasting = 8-12 hours, water & black coffee only)***		
Height:	Feet	inches	**Please circle one:**	L arm	R arm
Weight:	Pounds		**No. of attempts:**	**Initials:**	
Waist circumference:	Inches		**Place LabCorp Sticker Here:**		
Pulse: **Blood Pressure**	mmHG/	mmHG			

PATIENT TO COMPLETE:

NAME: _____ SSN: _____/_____/_____DOB:_____/_____/_____

Circle all conditions for which you are taking medications:

Blood Pressure	Liver Disease	Smoking Cessation	Diabetes
Weight Loss	Migraine Headaches	Gout	Asthma
Cholesterol	Heart Failure	Cancer Treatment	COPD

Have you smoked more than 100 cigarettes in your lifetime? Yes_____ No_____

If you smoke, how many cigarettes do you smoke some days or every day? _____

If you have stopped smoking, what year did you quit smoking? _____

How much of the time do you buckle your seat belt when driving or riding *(circle one)*? Never/rarely Sometimes Usually Always

How many days a week do you exercise at least 30 minutes? _____ days

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes_____ No_____

During the past month, have you often been bothered by feeling down or depressed? Yes_____ No_____

Have you had a Dental Exam in the past 12 months? Yes_____ No_____

Have you had an Eye Exam in the past 12 months? Yes_____ No_____

If you are female: Have you had a Pap Smear in the past 12 months? Yes_____ No_____

If you are female: Have you had a Mammogram in the past 12 months? Yes_____ No_____

If you are male: Have you had a Prostatic Specific Antigen (PSA) test in the past 12 months? Yes_____ No_____

The following medical intake questions are for the doctor to better manage your care. If your health plan includes incentives for HRA participation, then you may choose not to answer these questions without penalty.

If you are female:

Have you or anyone else in your immediate family (mother or sisters) had ovarian or breast cancer? Yes_____ No _____

If you are male:

Have you or anyone else in your immediate family (father or brothers) had prostate cancer? Yes_____ No _____

Has either parent had a stroke or heart attack? Yes_____ No _____