IMPERIAL HEALTH PLAN
OF CALIFORNIA

Please Return this HRA in the self-addressed envelope provided.

Health Risk Assessment (HRA)

Date:		Member ID:		Plan Start Date:	
First Name:		Last Name:		Date of Birth:	
Gender:		Phone Number:		Email:	

Section 1: About You (Personal Characteristics)

1 What is your race and/or ethnicity? *Select all that apply and enter details in the space provided.*

- ☐ **American Indian/Alaskan Native** *(for example, Navajo Nation, Nome Eskimo Community, etc.)*
- ☐ **Asian** *(for example, Chinese, Filipino, Indian, Vietnamese, etc.)*
- ☐ **Black/African American** *(for example, African American, Haitian, Ethiopian, etc.)*
- ☐ **Hispanic or Latino** *(for example, Mexican, Salvadoran, Puerto Rican, Cuban, etc.)*
- ☐ **Middle Eastern or North African** *(for example, Lebanese, Iranian, Egyptian, Syrian, etc.)*
- ☐ **Native Hawaiian/ Pacific Islander** *(for example, Native Hawaiian, Samoan, Fijian, etc.)*
- ☐ **White** *(for example, English, German, Irish, Italian, Polish, etc.)*
- ☐ **Other Group**, please write in:

Section 2: Health Conditions

2 Have you ever had any of these health problems? (Check all that apply)

☐ Asthma	☐ Diabetes	☐ Stroke (incl. Brain Bleed)
☐ Depression, Bi-polar, or Schizophrenia	☐ Bladder or Bowel Problems	☐ Vision or Eye Problems
☐ Cancer (including Leukemia)	☐ Hearing Loss	☐ Seizures
☐ COPD or lung disease	☐ Severe Obesity	☐ Blood Vessel Disease
☐ Pneumonia or other lung infections	☐ High Blood Pressure	☐ Drug or Alcohol Problems
☐ Dementia or Memory Loss	☐ Foot Problems	☐ Past Organ Transplant(s):
☐ Liver Disease (End-Stage)	☐ Kidney Disease (Stage 5)	Which organ? _____
☐ Rheumatoid Arthritis, Joint Problems	☐ HIV or AIDS	Transplant Date: _____
☐ Paralysis (Quadriplegia)	☐ Heart Disease, Heart Failure	☐ Other: _____
☐ Trouble moving one side of the body	☐ Irregular Heartbeat	☐ None

Section 3: Your Health & Doctor Visits (Preventive Care)

3 How would you rate your current health?
☐ Excellent ☐ Fair
☐ Very Good ☐ Poor
☐ Good

4 Do you use tobacco products?
☐ Yes, cigarettes or cigars
☐ Yes, vape pens
☐ None

5 When was your last check-up?

6 When was your last mammogram?

7 When was your last blood test?

8 When was your last colon cancer screening?

9 Do you regularly do any kind of physical activity or exercise?
☐ Yes ☐ No

10 Have you been offered a palliative care visit to help manage chronic conditions?
☐ Yes ☐ No

11 Overall, how comfortable are you with performing these activities of daily living?

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	Eating ☐ Can do independently ☐ Need Assistance		Brushing hair, brushing teeth, shaving, clipping nails, etc.? ☐ Can do independently ☐ Need Assistance
	Dressing and Undressing ☐ Can do independently ☐ Need Assistance		Getting in and out of bed and moving around freely? ☐ Can do independently ☐ Need Assistance
	Using the toilet ☐ Can do independently ☐ Need Assistance		Bathing or showering completely ☐ Can do independently ☐ Need Assistance
12	If you have diabetes or a heart condition, are you taking a statin (cholesterol medicine)? ☐ Yes ☐ No	13	When was your last dilated retinal (eye) exam? Exam Date: _____ Location: _____ Was retinopathy found? ☐ Yes ☐ No
14	What was the A1c level from your last blood test? Test Date: _____ Level: _____	15	When was your last kidney (urine or eGFR) test? Test Date: _____ Results (if known): _____
16	When was your last blood pressure reading? Reading Date: _____ BP levels: ____/____ Location of Reading: ☐ Home ☐ Doctor's Office	17	Have you received any of the following vaccines this year? **Flu** ☐ Yes ☐ No **Pneumonia** ☐ Yes ☐ No **COVID** ☐ Yes ☐ No **Others** ☐ Yes ☐ No
18	If you do not get vaccinated regularly, why?	19	If you received other vaccine(s) this year, which did you receive?
20	How would you describe your eating habits? ☐ Healthy and balanced ☐ Somewhat healthy ☐ Unhealthy or not regular meals	21	Do you currently drink alcohol or use recreational drugs or substances? ☐ Yes, regularly ☐ Yes, occasionally ☐ No or prefer not to say
22	How many times have you been admitted to a hospital in the past 12 months? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ More than 5 times	23	How many times have you gone to the emergency room (ER) in the past 12 months? ☐ 0 ☐ 1-3 ☐ 4-7 ☐ More than 7 times
24	Have you had any stays at a Skilled Nursing Facility (SNF) or Acute Rehab Facility in the past 12 months? ☐ Yes ☐ No		
Section 4: Moving and Balance (Risk of Falling)			
25	Have you fallen in the past year? ☐ Yes ☐ No	26	Do you feel unsteady while walking or standing? ☐ Yes ☐ No
27	Do you need help walking or standing? ☐ Yes ☐ No	28	Has your doctor conducted a timed walk test that lasted 12 seconds or more? ☐ Yes ☐ No
29	Do you have trouble seeing clearly? ☐ Yes ☐ No	30	Have you had a vision test in the past year? ☐ Yes ☐ No
Section 5: Medicines, Allergies, & Pain			
31	Do you take prescription medicines? ☐ Yes ☐ No If yes, how many? _____ List all known medications: _____		
32	Do any medicines make you dizzy, sleepy, or confused? ☐ Yes ☐ No	33	Do you currently have pain or discomfort? ☐ No ☐ Yes. If yes, where? _____ What is the level of pain on a scale from 0 – 10? _____ *(0 = No Pain, 10 = Worst Ever)* _____

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34	Do you have any known allergies? ☐ Yes ☐ No If yes, list the allergens: _____	35	Do you get extra help from Medicare to pay for your medications? ☐ Yes ☐ No

Section 6: Support & Social Life

36	Do you feel safe at home? ☐ Yes ☐ No	37	Do you have a caregiver helping you now? ☐ Yes ☐ No If yes, how many days each week? _____
38	Do you have family members or others who are willing and able to help you when you need it? ☐ Yes ☐ No		
39	Do you ever think your caregiver has a hard time giving you all the help you need? ☐ Yes ☐ No		
40	How often do you speak with or see close friends/family? ☐ Less than once a week ☐ 1–2 times a week ☐ 3–5 times a week ☐ More than 5 times a week		

Section 7: Housing & Transportation

41	What is your housing situation today? ☐ I have a steady place to live ☐ I have a place to live today, but I am worried about losing it in the future ☐ I do not have a steady place to live *(I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)*
42	In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? *(check all that apply)* ☐ Yes, it has kept me from medical appointments or getting medications ☐ Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need ☐ No

Section 8: Food & Utilities

43	Within the past 12 months, you worried that your food would run out before you got money to buy more. ☐ Often true ☐ Sometimes true ☐ Never true
44	In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home? ☐ Yes ☐ No ☐ Already shut off

Section 9: Mood and Emotional Health

45 In the past two weeks, how often have you been bothered by any of the following problems?

Check one box for each statement:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
	0	1	2	3
Lost interest or joy in things:	☐	☐	☐	☐
Feeling down, depressed, or hopeless:	☐	☐	☐	☐

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