



Dear Puget Sound Health Partners Member:

We are very eager to serve you and assure that you get the very best of care and service. The following Health Survey will help your Primary Care Physician understand your health care needs and assist her or him to coordinate services for you. This information will be kept strictly confidential and shared only with your physician. This important information will become part of your medical record in your physician's office and will assist your care team to provide you with the right care at the right time.

Puget Sound Health Partners provides you with annual prevention check-ups at no charge to you. We encourage you to see your primary care physician at least once every year so that your care is planned and coordinated.

As a token of our appreciation for your time completing this important questionnaire a small gift is enclosed.

If you have any questions about this survey or about any aspect of your membership in Puget Sound Health Partners please do not hesitate to call us at **1-866-789-7747** Monday – Friday between the hours of 8am – 5pm (for the hearing impaired TTY/TDD call 1-866-264-4141). In partnership with your physician we are committed to serve all your health care needs. Thank you for your participation.

A handwritten signature in black ink, appearing to read "Hugh Straley".

Hugh Straley, M.D.  
Chief Medical Officer  
Puget Sound Health Partners



## Member Health Survey

Member Name (*print*): \_\_\_\_\_

Address/P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Male       Female      Email Address: \_\_\_\_\_

Primary Language:       English       Spanish       Russian  
 Other \_\_\_\_\_

Primary Care Physician (PCP) Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### **HEALTH SERVICES (PLEASE CHECK ALL THAT APPLY TO YOU)**

How many times in the last six (6) months were you admitted to a hospital for care?

None       1-2       3+

How many times in the last six (6) months did you go to the Emergency Room (ER) for treatment?

None       1-2       3+

A fall is when your body goes to the ground without being pushed. Have you fallen in the last 12 months?

Never       Once       Several Times

**PERSONAL HEALTH HISTORY (PLEASE CHECK ALL THAT APPLY TO YOU)**

Do you smoke now?  Yes  No

How often do you exercise (walk or jog, use an exercise machine, go to an exercise or yoga class, etc.) **per week**?

Once a week  Twice a week  
 More than 3 times a week  Never

How many different medications (excluding vitamins) do you take a day?

None  2  3-4  5+

How would you rate your health overall?

Poor  Fair  Good  Excellent

Over the past two (2) weeks how often have you been bothered by either of the following feelings?

1. Little interest or pleasure in doing things

Not at all  Several days  More than half the time  Every day

2. Feeling down, depressed, or helpless

Not at all  Several days  More than half the time  Every day

Would you like help regarding these feelings (phone call or an appointment)?

Yes  No

During the last five (5) years, have you had or are currently being treated for any of the following conditions? *(check appropriate answer)*

Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
COPD/Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congestive Heart Failure (CHF)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack or Coronary Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No

- |                                    |                              |                             |
|------------------------------------|------------------------------|-----------------------------|
| Irregular Heart Beat               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression or Mental Health Issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Drug or Alcohol Addiction          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Disease                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes (high blood sugar)        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Do any health conditions interfere with your daily activities?

Yes       No

If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you live alone?       Yes       No

In the event that you become ill or incapacitated, do you have a spouse, relative, or friend who is able to care for you?

Yes       No

## **ADVANCE DIRECTIVES**

An Advance Directive, or living will, is a legal document that tells how you want medical decisions made if you are not able to make them yourself. You can accept or refuse medical care. There are many issues to address including:

- The use of dialysis and breathing machines
- If you want to be resuscitated if breathing or heartbeat stops
- Tube feeding
- Organ or tissue donation

Do you have an Advance Directive in place?       Yes       No

Does your PCP have a copy of your Advanced Directive?       Yes       No

*This completes the Health Survey. Thank you very much for your time and effort completing this important form. This information will assist us and your physician in providing you with needed services. Please return in the completed survey in the enclosed self-addressed stamped envelope.*

