Health Survey

MVP Health Care® wants to help keep you healthy. The information you provide in this survey will only be used to assess the condition of your overall health and to determine if one of our nurses or case managers can assist you with your health care needs. If you would prefer to complete this survey over the phone, please call MVP Member Services/ Customer Care Center at **1-800-852-7826** (TTY: 1-800-662-1220). Your answers will be kept confidential and are not used to determine eligibility for health insurance.

Please complete one survey for each member of your family who has been enrolled in the MVP Medicaid program.

Section 1: MVP Member Information *(please print)*

Member Name	MVP Subscriber ID

Date of Birth	Home Phone No.	Alternate Phone No.

Section 2: Health Questions—these questions apply to you only.

1. What is the primary language spoken in your home? ☐ English ☐ Spanish ☐ Other: _____

If English is not your primary language, is there someone who can interpret for you? ☐ Yes ☐ No

If ***Yes***, who is that person? _____

2. Who is your Primary Care Physician? _____

3. Have you had a recent physical? ☐ Yes ☐ No

If ***Yes***, tell us of any health problems identified that we can help you with.

_____

_____

4. If you have not had a recent physical, do you need help with any of the following to make an appointment?

☐ Transportation ☐ Choosing a new health care provider ☐ Other: _____

5. Are you on any medications at this time? ☐ Yes *(list all below)* ☐ No

Medications Prescribed by Provider	Over-the-Counter Herbal Supplements/Medications

6. Are you receiving any of the following long-term services?

☐ Home care by a nurse ☐ Personal care ☐ Consumer Directed Personal Assistance Services (CDPAS)

☐ Private duty nursing ☐ Adult day care ☐ Other: _____

7. Do you smoke? ☐ Yes ☐ No If ***Yes***, do you want help to stop smoking? ☐ Yes ☐ No

8. Do you have hepatitis C? ☐ Yes ☐ No

9. Please check each health question or on-going medical issue below for which you are being treated.

	For any condition checked, have you been seen in the emergency room or admitted to the hospital within the past year for this condition?
☐ **Pregnancy** (currently pregnant)	☐ Yes How many times?
☐ Heart problems	☐ Yes How many times?
☐ High blood pressure	☐ Yes How many times?
☐ Diabetes	☐ Yes How many times?
☐ Asthma	☐ Yes How many times?
☐ Emphysema or COPD	☐ Yes How many times?
☐ Stroke or transient ischemic attack (TIA)	☐ Yes How many times?
☐ Cancer (indicate part of the body affected)	☐ Yes How many times?
☐ Kidney problems	☐ Yes How many times?
☐ Depression-sadness, anxiety, or panic attacks lasting more than two weeks	☐ Yes How many times?
☐ Problems with drugs or alcohol	☐ Yes How many times?
☐ Problems with high cholesterol	☐ Yes How many times?
☐ Seizures (fits or convulsions)	☐ Yes How many times?
☐ Tuberculosis (TB)	☐ Yes How many times?
☐ Thyroid problems	☐ Yes How many times?
☐ Blood disease such as Sickle Cell Anemia	☐ Yes How many times?
☐ Problems with your eyesight	☐ Yes How many times?
☐ Hearing problems	☐ Yes How many times?
☐ Other, please explain:	☐ Yes How many times?

10. Please tell us of any other issues or questions that we can assist you with.

If you have any questions, please contact MVP Member Services/Customer Care Center at **1-800-852-7826** (TTY: 1-800-662-1220). Thank you for taking the time to complete this Health Survey. We look forward to assisting you and your family with your health care needs. Please return your completed Health Survey to:
ATTN: MEDICAID DEPARTMENT, MVP HEALTH CARE, 625 STATE ST, SCHENECTADY NY 12305-2111.