OneCare Kansas
a program of KanCare, Kansas Medicaid

Adult Health Assessment

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About You:

Name: _____ Last 4 of SS#: _____

Do you have a personal primary care physician for your healthcare needs?
☐ Yes ☐ No If yes, name of physician: _____

Do you have a therapist for your behavioral health needs?
☐ Yes ☐ No If yes, name of therapist: _____

Do you have vision problems that require the use of tools or products to help you read or use the Internet?
☐ Yes ☐ No

Do you have hearing loss and use hearing aids or other tools or products to help you communicate?
☐ Yes ☐ No

Lifestyle:

How many fruits and vegetables do you eat in an average day? A fruit or vegetable is equal to 2 cups of leafy greens; 1 cup of raw or cooked veggies, fresh fruit, or 100% juice; or 1/2 cup of dried fruit.
☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 9 or more

How many sugary drinks do you have in an average day? Examples of sugary drinks are regular soda or pop, sports or energy drinks, and fruit drinks with added sugar.
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

How many foods that you think are unhealthy do you eat in an average day? Examples of unhealthy foods are chips, fried or fast foods, cookies, doughnuts, and candy.
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Did You Know??? You know that exercise is good for your heart, lungs, muscle tone, and appearance. But did you know that regular moderate exercise can help with stress and depression, too?

How often do you do the following kinds of exercise?

- Exercise that works your heart, like jogging, cardio machines, aerobic dancing, brisk walking, swimming, or other such exercise?
  _____ days per week _____ minutes per session

- Strength-building exercise, like weightlifting, push-ups, sit-ups, yoga, pilates, or other such exercise?
  _____ days per week _____ minutes per session

How many alcoholic drinks do you usually have in a week? _____ drinks per week

- One drink = One 12 oz bottle of beer or hard cider
  One 5 oz glass of wine
  One 1.5 oz shot or distilled spirits

Do you smoke cigarettes?
☐ currently use ☐ previously used ☐ never used

If currently use: How many years? _____ How many do you typically smoke per day? _____

Do you use other forms of tobacco (cigars, pipes, snuff, chewing tobacco?
☐ currently use ☐ previously used ☐ never used

Are you exposed to secondhand tobacco smoke more than once a week for 30 minutes or longer?
☐ Yes ☐ No

Well-Being:

Did You Know??? Sleep is an important factor in health, and a lack of restful sleep can increase risks for weight gain, heart disease and depression.

How many hours do you typically sleep per night? _____ hours

Do you generally feel well-rested after sleeping?
☐ always ☐ most of the time ☐ sometimes ☐ rarely ☐ never

Medical:

In the past year, excluding pregnancy, approximately how many times have you:

- Been to the doctor or clinic? _____ times
- Been hospitalized overnight? _____ times
- Been to the emergency room? _____ times

Do you take medications for any chronic conditions? ☐ Yes ☐ No

- List medications:

_____
_____

Do you have any concerns about your medications? ☐ Yes ☐ No

- If yes, please list:

_____
_____

Do you have any allergies to medications, or anything else? ☐ Yes ☐ No

- If yes, please list all allergies:

_____
_____

Do you use any medical equipment currently? ☐ Yes ☐ No
(e.g., cane, walker, crutches, nebulizer, diabetic supplies, etc)

- If yes, please list:

_____

_____

Do you need any help with Activites of Daily Living? ☐ Yes ☐ No
(e.g., bathing, medication, feeding, etc)

- If yes, please list:

_____

_____

Conditions:

Has a doctor ever diagnosed you with:

- Allergies ☐ Yes ☐ No
- Ankle/leg swelling ☐ Yes ☐ No
- Arthritis ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No
- Chronic obstructive pulmonary disease (COPD) or emphysema ☐ Yes ☐ No
- Chronic pain ☐ Yes ☐ No
- Colon polyps ☐ Yes ☐ No
- Diabetes Type 1 ☐ Yes ☐ No
- Diabetes Type 2 ☐ Yes ☐ No
- Depression ☐ Yes ☐ No
- Dialysis ☐ Yes ☐ No
- Heart problems ☐ Yes ☐ No
- High blood pressure ☐ Yes ☐ No
- High cholesterol ☐ Yes ☐ No
- Menopause (women only) ☐ Yes ☐ No
- Migraine headaches ☐ Yes ☐ No
- Osteoporosis ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- Sleep disorder ☐ Yes ☐ No
- Thyroid disease ☐ Yes ☐ No
- Urinary problems (e.g. leaking urine) ☐ Yes ☐ No
- Other condition: _____

If yes is answered to any of the above conditions, ask the following of each condition: Please use additional pages if more conditions are present.

Condition: _____
Do you currently have symptoms? ☐ Yes ☐ No
How much does the condition impact your daily life?
☐ not much ☐ moderately ☐ severely

How well are you managing the condition?
☐ it's under control ☐ it could be better ☐ it's not going well

Are you currently being treated? ☐ Yes ☐ No
How often do you miss a dose of medication for your condition?
☐ rarely ☐ sometimes ☐ often ☐ I don't take medication for this condition

Condition: _____
Do you currently have symptoms? ☐ Yes ☐ No

How much does the condition impact your daily life?
☐ not much ☐ moderately ☐ severely

How well are you managing the condition?
☐ it's under control ☐ it could be better ☐ it's not going well

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☐ rarely ☐ sometimes ☐ often ☐ I don't take medication for this condition

Lab Tests:

Your health numbers provide important information about your overall health.

Do you know your blood pressure?	☐ Yes	☐ No
Do you know your total cholesterol?	☐ Yes	☐ No
Do you know your LDL (the "bad") cholesterol?	☐ Yes	☐ No
Do you know your HDL (the "good") cholesterol?	☐ Yes	☐ No
Do you know your triglyceride level?	☐ Yes	☐ No
Do you know your blood sugar level?	☐ Yes	☐ No
Do you know your hemoglobin A1c level?	☐ Yes	☐ No

Preventive Screenings and Exams:

Early detection saves lives. When did you last have the following health screenings?

Cervical cancer screening (Pap smear) ☐ Not applicable
☐ I know the approximate date: _____ with Dr. _____
☐ Less than 1 year ago ☐ 1 to less than 2 years ago ☐ 2 to less than 3 years ago
☐ 3 to less than 5 years ago ☐ 5 or more years ago ☐ Never

Prostate Exam ☐ Not applicable
☐ I know the approximate date: _____ with Dr. _____
☐ Less than 1 year ago ☐ 1 to less than 2 years ago ☐ 2 to less than 3 years ago
☐ 3 to less than 5 years ago ☐ 5 or more years ago ☐ Never

Colonoscopy
☐ I know the approximate date: _____ with Dr. _____
☐ Less than 1 year ago ☐ 1 to less than 2 years ago ☐ 2 to less than 3 years ago
☐ 3 to less than 5 years ago ☐ 5 or more years ago ☐ Never

Physical exam or wellness visit
☐ I know the approximate date: _____ with Dr. _____
☐ Less than 1 year ago ☐ 1 to less than 2 years ago ☐ 2 to less than 3 years ago
☐ 3 to less than 5 years ago ☐ 5 or more years ago ☐ Never

Eye doctor appointment
☐ I know the approximate date: _____ with Dr. _____
☐ Less than 1 year ago ☐ 1 to less than 2 years ago ☐ 2 to less than 3 years ago
☐ 3 to less than 5 years ago ☐ 5 or more years ago ☐ Never

Dental appointment
☐ I know the approximate date: _____ with Dr. _____

☐ Less than 1 year ago ☐ 1 to less than 2 years ago ☐ 2 to less than 3 years ago
☐ 3 to less than 5 years ago ☐ 5 or more years ago ☐ Never

Are you up to date on your immunizations? ☐ Yes ☐ No
Have you had the flu shot in the last 12 months? ☐ Yes ☐ No
Have you had the pneumonia vaccine? ☐ Yes ☐ No
Have you had the shingles vaccine? ☐ Yes ☐ No
When was your last tetanus shot? _____ (if unknown it is recommended to get one)

How ready are you to make health changes below?

Get more cardiovascular exercise?
☐ I have no need to ☐ I have been more than 6 months ☐ I have been less than 6 months
☐ I plan to within the next month ☐ I plan to within next 6 months ☐ I have no plans to

Get more strength-building exercise?
☐ I have no need to ☐ I have been more than 6 months ☐ I have been less than 6 months
☐ I plan to within the next month ☐ I plan to within next 6 months ☐ I have no plans to

Eat better?
☐ I have no need to ☐ I have been more than 6 months ☐ I have been less than 6 months
☐ I plan to within the next month ☐ I plan to within next 6 months ☐ I have no plans to

Manage your weight better?
☐ I have no need to ☐ I have been more than 6 months ☐ I have been less than 6 months
☐ I plan to within the next month ☐ I plan to within next 6 months ☐ I have no plans to

Get current with your preventive screenings and exams?
☐ I have no need to ☐ I have been more than 6 months ☐ I have been less than 6 months
☐ I plan to within the next month ☐ I plan to within next 6 months ☐ I have no plans to

Manage your stress better?
☐ I have no need to ☐ I have been more than 6 months ☐ I have been less than 6 months
☐ I plan to within the next month ☐ I plan to within next 6 months ☐ I have no plans to

Improve your sleep habits?
☐ I have no need to ☐ I have been more than 6 months ☐ I have been less than 6 months
☐ I plan to within the next month ☐ I plan to within next 6 months ☐ I have no plans to

How confident are you that you can make healthy changes?
☐ Extremely confident ☐ Very confident ☐ Confident
☐ Somewhat confident ☐ Not at all confident