Date: _______________

PPO Health Risk Assessment

This assessment helps ATRIO Health Plan coordinate care specific to your needs. This is an optional assessment, **any information provided does not affect your benefits or enrollment.** Return Instructions are on Page 2.

Member name: ____ **Date of birth:** ______________________

Phone number: __________________________ **Cell Phone:**__________________________ **Ok to text: Y N**

County of residence: _____________________ **Email address:** ___________________________________

Preferred language: ______________________ **Insurance Agent:** ________________________________

This questionnaire is being completed by: Self ☐ Spouse/Partner ☐ Caretaker ☐ Other ☐ Agent ☐

Name of Primary Care Doctor/Provider or Clinic: ____

Please answer the following questions to the best of your ability. Circle 'yes' or 'no' for each question below:

1. Have you been to your regular doctor in the last 12 months? YES NO
2. Do you take your medications as prescribed? YES NO
3. Do you take more than 5 medications? YES NO
4. Have you been hospitalized or in the emergency room in the past 12 months? YES NO
    a. If yes, did you follow up with your primary care provider within 30 days? YES NO
5. Have you fallen down in the past 12 months? YES NO
6. Do you have family or friends to help with your medical needs? YES NO
7. Did you receive an annual flu vaccination this year? YES NO
8. Have you had a mammogram in the last two (2) years? YES NO

If yes, Year______________ Location____

9. Have you had a colonoscopy in the last ten (10) years? YES NO

If yes, Year______________ Location____

What chronic health conditions do you have? Circle 'yes' or 'no' for each condition below:

a.	Alzheimer's or Dementia	YES	NO
b.	Amputation	YES	NO
c.	Artificial opening (colostomy, tracheostomy, gastrostomy, etc)	YES	NO
d.	Cancer If yes, Type ____________________________________Year____________________	YES	NO
e.	COPD	YES	NO
f.	Depression/Anxiety	YES	NO
g.	Diabetes	YES	NO
	If yes, do you test your blood sugar daily?	YES	NO
	Have you had an A1C test within the last six (6) months?	YES	NO
	Have you had your annual Diabetic eye exam?	YES	NO
h.	Heart disease (example: CHF, AFib, history of heart attack)	YES	NO
i.	High blood pressure (hypertension)	YES	NO
j.	High cholesterol	YES	NO
k.	Kidney disease or renal failure	YES	NO
	If yes, are you on dialysis?	YES	NO
l.	Rheumatoid Arthritis	YES	NO
m.	Stroke	YES	NO

An ATRIO nurse may follow up with you in response to these questions. This is an optional service that ATRIO offers. Is it ok for an ATRIO nurse to contact you? ☐ Yes ☐ No

Please return this form to a local ATRIO office or mail back to the following address:

ATRIO Health Plans
Attn: HRA
2965 Ryan Drive SE
Salem, OR 97301