Humana Healthy Horizons® Health Risk Assessment

Please fill out all of the required fields in this form so that this information may be used to refer you to care management programs, which may help you live a healthier life.

Enrollee name* ____________________

Enrollee address ____________________

Enrollee phone ____________________

Enrollee date of birth* ____________________ Age __________

Enrollee ID number ____________________

Emergency contact name ____________________ Phone __________

Date completed ____________________

Who is completing this form for you? ____________________

1. What was your sex at birth?

Female

Male

Decline to answer

2. What gender do you currently identify with?

Female

Male

Other

Decline to answer

Female-to-male/Transgender male/Trans man

Male-to-female/Transgender female/Trans woman

Genderqueer/Nonbinary, neither exclusively male or female

3. What are your pronouns?

She/her/hers

He/him/his

They/them/theirs

Other

Decline to answer

4. What is your sexual orientation?

Straight or heterosexual

Lesbian, gay or homosexual

Bisexual

Something else

Don't know

Decline to answer

5. What is your race or ethnicity?

African American	American Indian or Alaskan Native	Asian	Native Hawaiian or Pacific Islander
White/non-Hispanic	Hispanic or Latino	Multiracial	Other

6. What is your highest level of education?

Elementary school	Middle school (6–8)	High school (9–12)	High school graduate
Some college	College graduate	Graduate school	N/A

7. What is your preferred language to speak at home?

English	Spanish	Other

8. What is your living situation?

Own	Rent	Live with family	Live with friends
Homeless	Other		

9. Are you currently pregnant?

Yes	No

10. Has a doctor ever told you that you have the following? (Mark all that apply)

Diabetes	High blood pressure	Heart disease	Kidney disease
Cancer	Asthma	COPD	Allergies
HIV/AIDS	Hepatitis	Depression	Anxiety
Bipolar disorder	Schizophrenia	N/A	

11. Do you currently take prescription medicine?

Yes	No

12. Do you currently use any of the following? (Mark all that apply)

- Hearing aids
- Glasses or contacts
- Wheelchair or walker
- Other assistive devices
- N/A

13. How often do you exercise?

- Two to three times a week
- Once a week
- Rarely
- Never

14. How often do you use alcohol?

- Every day
- Two or more days per week
- Rarely
- Never

15. Do you use tobacco or tobacco products?

- Yes
- No
- I would like help quitting.

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings.)

- Less than once a week
- 1 or 2 times a week
- 3 to 5 times a week
- 5 or more times a week
- I choose not to answer this question.

17. Stress is when someone feels tense, nervous, anxious or can't sleep at night because their mind is troubled. How stressed are you?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much
- I choose not to answer this question.

18. In general, how would you rate your overall health?

- Excellent
- Very good
- Good
- Fair
- Poor

19. Do you need help with any of the following? (Mark all that apply)

- Clothing
- Employment
- Financial
- Food
- Healthcare access
- Housing
- Mobility
- Safety
- Social support
- Transportation
- Utilities
- Other
- N/A

20. Do you need help performing any of the following daily activities? (Mark all that apply)

- Accessing medication
- Bathing
- Eating
- Dressing
- Shopping
- Managing finances
- N/A

21. Compared to one year ago, my health is worse.

- Yes
- No

22. Have you received dental care in the past year?

- Yes
- No

23. Have you been to the emergency room in the last three months?

- Yes
- No

24. Would you like your health plan to contact you about any other health concerns?

- Yes
- No