



SIMPLY HEALTHCARE PLANS, INC.

Health Risk Assessment Form

Date: _____ Member Name: _____

Member I.D.# _____ Date of Birth: _____ Male Female

Address: _____ City/State/Zip _____

Home Phone#: _____ Day Phone#: _____ Cell Phone# _____

Primary Care Doctor: _____ Language Preferred: English ____, Spanish ____, Other _____

Previous Primary Doctor: _____ Phone#: _____

Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like to get information on how you can stop smoking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are Immunizations (childhood shots) up to date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, when is your expected delivery date? _____		
Are you getting WIC?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you getting services from the Florida Healthy Start Program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a baby within the past 2 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like information about Family Planning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like information on Teen Pregnancy Prevention?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like information on Substance Abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like information on Domestic Violence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking any medicines?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, list which ones		
1. _____ 2. _____ 3. _____		
Are you using any medical equipment, like a glucometer, nebulizer or wheelchair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, list equipment _____		
Have you been treated in an Emergency Room?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, for what reason/when _____		
Are you receiving treatment (seen by a doctor) for any of the medical conditions listed below?		
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please return completed form to: SIMPLY HEALTHCARE PLANS, P.O. Box 830010, Miami, FL 33283