General Assessment

Member Name:		UCare Number:
DOB:	**UCare Product:**	**Date Completed:**

Health History

Hospitalizations in last 12 months	
Number:	**Please describe**:
ER Visits in last 12 months	
Number	**Please describe**:
Do you have any of the following health conditions?	
Neurological: ☐ Yes ☐ No If yes, what?	**Cardiac**: ☐ Yes ☐ No If yes, what?
Respiratory: ☐ Yes ☐ No If yes, what?	**GI**: ☐ Yes ☐ No If yes, what?
Endocrine: ☐ Yes ☐ No If yes, what?	**Orthopedic**: ☐ Yes ☐ No If yes, what?
Renal: ☐ Yes ☐ No If yes, what?	**Autoimmune**: ☐ Yes ☐ No If yes, what?
Other: ☐ Yes ☐ No If yes, what?	

Preventative Care

Have you had any of the following tests or exams within the last 12 months?	If No, would you like your CM to assist scheduling?
Annual Physical or wellness exam? Choose an Item **Comments**	**Yes** ☐ **No** ☐
Dental Exam? Choose an Item **Comments**	**Yes** ☐ **No** ☐
Vision Exam? Choose an Item **Comments**	**Yes** ☐ **No** ☐
Mammogram? Choose an Item **Comments**	**Yes** ☐ **No** ☐
Prostate Exam or PSA test? Choose an Item **Comments**	**Yes** ☐ **No** ☐
Colorectal screening? Choose an Item **Comments**	**Yes** ☐ **No** ☐
Flu Shot? Choose an Item **Comments**	**Yes** ☐ **No** ☐
Pneumonia Shot? Choose an Item **Comments**	**Yes** ☐ **No** ☐
For members with diabetes only. **Have you had any of the following tests within the last 12 months?**	**If No, would you like CM to assist scheduling?**
A1C test? Choose an Item **Kidney function (nephropathy) test?** Choose an Item **Comments**	**Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐

Activities of Daily Living

Do you need assistance with any of the following (check all that apply). If yes, please describe needs.

☐ **Ambulating/transferring**	☐ **Grooming**	☐ **Dressing**	☐ **Bathing**
☐ **Going to the bathroom**	☐ **Meal Preparation**	☐ **Eating**	

Comments:

Home Safety

Do you feel safe within your current living arrangement? ☐ Yes ☐ No ☐ Chose not to answer

- **If no, list circumstances:**

Do you have any safety concerns about your living arrangement? *(i.e. cords, rugs, stairs)*
☐ Yes ☐ No ☐ Chose not to answer

- **If yes, describe**:

Have you fallen in the past 12 months?
☐ Yes ☐ No ☐ Chose not to answer

Comments:

Medications *(Prescribed and Over-the-counter)*

Please list all medications and supplements you are taking. Include name, dose and frequency taken.

How do you organize your medications? *(i.e. med box, dispenser, etc.)*Click here to enter text.
Do you ever miss doses of your medications? ☐ Yes ☐ No ☐ Chose not to answer
If yes, please explain why:

Advanced Directives

Do you have any of the following in place? ***(Check all that apply)***

☐ Advance Directives ☐ Living Will ☐ Durable Power of Attorney for Health Care
☐ Durable Power of Attorney for Financial

If none of the above were listed, was a discussion about Advance Directives completed?
☐ Yes ☐ No

- **If no, why not?**

Additional Comments:

Case Manager Signature: _____ **Date:**

Type CM Name and Credentials: