UnitedHealthcare®

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Please read and answer all the questions to the best of your ability by filling in oval by using blue or black ink.

Current health conditions *(Please mark each condition that applies to you.)*

1. What health conditions do you currently have?

- ◯ Heart attack in the past
- ◯ High blood pressure, high cholesterol, or other type of heart disease
- ◯ Heart failure or an enlarged heart
- ◯ Emphysema, COPD, asthma, or any other type of chronic lung disease
- ◯ Kidney dialysis
- ◯ Diabetes or blood sugar problems
- ◯ Depression, anxiety, or other mental health conditions
- ◯ Other conditions
- ◯ None

Help at home *(We want to know how easy or hard it is for you to get around.)*

2. Do you have any trouble getting around at home or outside your home? ◯ Yes ◯ No

3. Do you use a cane, wheelchair or walker to move around at home or outside your home? ◯ Yes ◯ No

4. Do you need the help of another person to move around inside or outside your home? ◯ Yes ◯ No

5. Do you need to stay in your home most or all of the time? ◯ Yes ◯ No

6. Do you need to stay in bed most or all of the time? ◯ Yes ◯ No

7. Do you need help at home due to health problems? ◯ Yes ◯ No

8. Has it been hard for you to get the help you need? ◯ Yes ◯ No

9. Do you provide care for or look after someone who needs assistance with their care? ◯ Yes ◯ No

Prescription drugs

10. Do you take any prescription drugs? ◯ Yes ◯ No

11. Do you use 8 or more different medications? ◯ Yes ◯ No

Hospital stays in the last year

12. In the previous 12 months, have you stayed overnight as a patient in the hospital? ◯ Yes ◯ No

13. About how many times?

◯ 1 Time ◯ 2 - 3 Times ◯ 4 or More Times

Memory and mood

14. Are you being treated for memory loss or have you been told you have serious memory loss?

◯ Yes ◯ No

During the past month, have you often been bothered by:

15. Little interest or pleasure in doing things? ◯ Yes ◯ No

16. Feeling down, depressed or hopeless? ◯ Yes ◯ No

Other

17. How confident are you in filling out medical forms by yourself?

◯ Not at all ◯ A little ◯ Somewhat ◯ Quite ◯ Extremely

Please mail this survey in the postage-paid envelope provided to HEALTH SURVEY PROCESSING CENTER 310 S RACINE AVE, CHICAGO IL 60607. Do NOT include your name on the envelope or survey and do NOT include anything beyond this survey in the envelope.