

HEALTHY ENDEAVORS^{SM1} PROGRAMS



The health information that you provide will be used to customize our program and will be shared with persons employed by or representing the Blue Cross and Blue Shield Service Benefit Plan to help them meet your individual needs. **The information that you provide will not affect your insurance premiums or your eligibility.** To complete the survey over the phone, call us at 1-888-392-3506. You may also fax your completed survey to 1-919-765-2081.

wR

**Please update incorrect or missing information.*

- I have not been diagnosed
- I do not want to participate at this time.

_____ **Policy holder signature* _____ *required for address change.*

Complete each question by filling in the circle completely, like this ●, next to your answer.

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

- Excellent Good Average Fair Poor

2. Have you ever been diagnosed with or have you had any of the following health conditions?

(Choose all that apply)

- Asthma
- Congestive Heart Failure- **please answer 25 & 26**
- Depression
- Diabetes- **please answer 22- 24**
- Heart disease or procedure
 - Heart Attack Angina
 - Bypass surgery Stent Placement
 - Coronary Artery Disease
- High Blood Pressure
- High cholesterol

3. **Based on the above diagnosis**, which Healthy Endeavors program would you like to be enrolled in?

- Asthma
- Diabetes
- Coronary Artery Disease*
- Congestive Heart Failure*

*If you have both of these diagnoses, you will receive the CHF packet.

4. During the last 2 weeks, have you often been bothered by feeling down, depressed, or hopeless?

- Yes No

5. In the past two weeks, have you experienced a loss of interest or pleasure in daily activities?

- Yes No

6. If you answered yes to both of the above or have been diagnosed with depression (or have another behavioral health condition) or if additional support may be helpful to you, please indicate if it would be ok to call you

- Yes No

If **yes**, when would you like a care manager to call?

- Morning 8am –12pm
- Afternoon 12pm – 5pm
- Early Evening 5pm – 8pm

Please list your phone number:

(_____) _____ - _____

7. Which phrase best describes your tobacco use?

- I don't use tobacco
- I haven't quit, but I'm thinking about it
- I have no desire to quit
- I don't use tobacco, but live with a smoker

8. Would you like information about helping you, or your family member, stop smoking?

- Yes No

9. What is your height? _____ Feet _____ Inches

10. What is your weight in pounds? _____

11. What is your waist measurement? _____

12. In the past 3 months, how many days did your health cause you to miss work for at least ½ day?

- Never 5-6 days
- 1-2 days 7 days or more
- 3-4 days Retired/Not employed

13. Over the past month, how many days did you accomplish less at work, school, or your daily activities due to your health?

- Never 5-6 days
- 1-2 days 7 days or more
- 3-4 days Retired/Not employed

Please turn page over to complete survey

14. How often do you exercise at a moderate or vigorous pace for more than 30 minutes?

- I don't like to exercise
- I can't exercise
- 1-2 days a week
- 3-4 days a week
- 5 or more days a week

15. What was the result of your last cholesterol test?

I don't know the exact results

16. When did you last have it tested?

- less than 6 months ago
- 3-5 years ago
- 6 months to 1 year ago
- Never
- 1-2 years ago
- Don't know

17. What was your last blood pressure reading?

Systolic (top)/Diastolic (bottom)

- I have had test, but I don't know the results.
- I haven't had it checked in more than 6 months.

18. Do you ever forget to take your medication?

- Yes
- No
- N/A

19. When you feel better do you sometimes stop taking your medication?

- Yes
- No
- N/A

20. Sometimes if you feel worse when you take your medication, do you stop taking it?

- Yes
- No
- N/A

21. Sometimes, do you forget to refill your prescription on time?

- Yes
- No
- N/A

Members with diabetes only:

22. How often do you check your blood sugar?

- 3 or more times a day
- Rarely
- 1-2 times a day
- Never
- A few times a week

23. What was your last Hemoglobin A1c test reading?

- 6 or lower
- Greater than 10
- 6.1 – 7.9
- Never had A1c test
- 8 – 10
- Not sure

24. When did you have your last A1c test?

- within 6 months
- over 1 year ago
- 6-12 months ago
- Never/don't remember

Members with heart failure only:

25. How often do you weigh yourself?

- Daily
- Rarely
- 1-2 times a week
- Weekly
- I do not own a scale

26. Do you experience:

Shortness of breath with activity?

- Yes
- No

Shortness of breath at rest?

- Yes
- No

Swelling or extra fluid?

- Yes
- No

Members with Asthma only:

27. Do you have an Asthma Management plan?

- Yes
- No
- N/A

28. Our specially trained Health Coaches offer telephonic assistance with questions, provide personalized health education and support, and help you work more effectively with your health care team. Would you like a call from a health coach?

- Yes
- No

If **yes**, when would you like a health coach to call?

- Morning 8am –12pm
- Afternoon 12pm – 5pm
- Early Evening 5pm – 8pm

Please list your phone number:

(____) _____ - _____

email _____

Thank you very much for completing this survey. Your enrollment materials will reach you within the next 2 weeks and, if you have chosen to work with a health coach, you will be contacted within the 2 week period.

Your signature confirms that you have read the above. You have made the choices. You wish to participate in our Healthy Endeavors program as described in the programs summary.

Signature

Date

_____/_____/____

(Please print your name)

You may call us if you have any questions at: Healthy Endeavors^{SM1} 888-392-3506