

# HEALTHY ENDEAVORS<sup>SM1</sup> 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.

*\*Please update incorrect or missing information.*

I do not want to participate at this time.

\_\_\_\_\_  
\_\_\_\_\_

Please feel free to visit for more information on healthy Lifestyle choices.

*\*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? **(Choose all that apply)**

- Asthma
- Congestive Heart Failure
- Type I Diabetes (Juvenile Diabetes)
- Type II Diabetes (Adult Onset Diabetes)
- Gestational Diabetes (Diabetes with Pregnancy)
- Coronary Artery Disease
- High Blood Pressure
- High Cholesterol
- Chronic Obstructive Pulmonary Disease (COPD)
- Tobacco Use (Self or Family Member)

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

- Asthma
- Diabetes
- Coronary Artery Disease
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Tobacco Cessation

4. 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

5. What is your height? \_\_\_\_\_ Feet \_\_\_\_\_ Inches

6. What is your current weight (in pounds)? \_\_\_\_\_

7. How many days a week do you exercise, and for how many minutes/day?

Days/Week \_\_\_\_\_ Minutes/Day \_\_\_\_\_

8. Have you had your cholesterol checked?

- Yes and I know the results (please see Q.9)
- Yes, but I don't know the exact results
- I don't know if I have ever had this test
- No

9. What was your last total cholesterol reading?

10. Have you had your blood pressure checked?

- Yes and I know the results (please see Q. 11)
- Yes, but I don't know the exact results
- I know if I have ever had this test
- No

11. What was your last blood pressure reading?

Systolic (top) / Diastolic (bottom)

**Members with Diabetes only:**

12. Have you had a Hemoglobin A1c reading?

- Yes and I know the results (please see Q16)
- Yes, but I don't know the exact results
- I don't know if I ever had this test
- No

13. Hemoglobin A1c reading

**Please turn page over to complete survey Eff**

**Members with Heart Failure only:**

14. How often do you weigh yourself?

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

**Members with Asthma only:**

15. Do you have an Asthma Management Plan?

- Yes
- No
- N/A

**Members with COPD only:**

16. Do you have a COPD Management Plan?

- Yes
- No
- N/A

**17. Our specially trained Registered Nurse Health Coaches offer telephonic assistance with questions, provide personalized health education and support. They also help you work more effectively with your physician and 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 8 am –12 pm
- Afternoon 12 pm – 5 pm
- Early Evening 5 pm – 8 pm

What day of the week would you prefer to be called?

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday Morning

Please provide your phone number:

( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_

Thank you very much for completing this survey. Your enrollment materials will be sent to you within 2 weeks from the time we receive your survey. If you have chosen to work with a health coach, you will be contacted within that same 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<sup>SM1</sup> 1-888-392-3506**

**Please visit our Website**  
[WWW.BCBSNC.COM/FEP](http://WWW.BCBSNC.COM/FEP)