HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Health Survey Form

Welcome to Health Plan of Nevada! We will do our best to keep you healthy and give you quality medical care. **Please take a few minutes to fill out this form.** We want to be able to contact you and to know about your special health care needs. **Your benefits will not be reduced because you answered these questions.** If you need help filling out this form, call us at **1-800-962-8074**, TTY **711** between 8 a.m. – 5 p.m., Monday - Friday.

Family members enrolled in Health Plan of Nevada's Medicaid or Nevada Check Up Program are:				
Adults' Name(s):	Date of Birth of Adult(s):	Medicaid ID #	Primary Care Provider:	Signature
1._____	1._____	1._____	1._____	1._____
2._____	2._____	2._____	2._____	2._____
3._____	3._____	3._____	3._____	3._____
4._____	4._____	4._____	4._____	4._____
5._____	5._____	5._____	5._____	5._____

Name of Child(ren):	Date of Birth of Child(ren):	Medicaid ID #	Primary Care Provider:	Up to date with all their shots?
1._____	1._____	1._____	1._____	1. ☐ No ☐ Yes ☐ Not sure
2._____	2._____	2._____	2._____	2. ☐ No ☐ Yes ☐ Not sure
3._____	3._____	3._____	3._____	3. ☐ No ☐ Yes ☐ Not sure
4._____	4._____	4._____	4._____	4. ☐ No ☐ Yes ☐ Not sure
5._____	5._____	5._____	5._____	5. ☐ No ☐ Yes ☐ Not sure

Address:	Telephone Number(s)/Email Address:
	Home: Work:
	Mobile: Email Address:
The language(s) we usually speak and read at home: ☐ English ☐ Spanish ☐ Other *(please write here):*	

**Please answer these questions to help us take better care of you and your family members who are enrolled in Health Plan of Nevada*: ** ** Please note these answers are confidential as governed by Federal and State Law, and will only be used to assist you with your medical care.

1. Does your child(ren) see Primary Care Provider for any special healthcare problem(s)? ☐ **No** ☐ **Yes:**
Name of child(ren) with special healthcare problem(s): _____
Please check the box(es) for the problem(s) that apply:

☐ Cancer ☐ Asthma ☐ Diabetes
☐ Sickle Cell Disease ☐ Hemophilia ☐ SUD (Substance Use Disorder)
☐ None ☐ Other Condition (please write specific issue): _____

Please complete and return this form to our Case Management Team, by placing it in the provided postage paid envelope.
Or mail it directly to us at: UnitedHealthcare Nevada Market, PO Box 15645, Las Vegas, NV 89195-8026.

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2. Has each child had a regular check-up with their doctor in the past year? ☐ **No** ☐ **Yes**
If "no," please list the names of the child(ren) whom have not had a check-up in the past year:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

3. During the past year, were you or anyone in your family admitted for an overnight stay in a hospital?
☐ **No** ☐ **Yes:**

- Name of Person(s) Admitted:
  1. _____
  2. _____
  3. _____
- For what problem?
  1. _____
  2. _____
  3. _____

4. During the past year, have you or anyone in your family received medical care in a hospital emergency room?
☐ **No** ☐ **Yes:**

- Name of Person(s) Admitted:
  1. _____
  2. _____
- For what problem?
  1. _____
  2. _____

5. Have you ever been told you have one or more of the following medical conditions? ☐ **No** ☐ **Yes:**

☐ Cancer
☐ Heart Failure or enlarged heart
☐ Asthma, COPD, or other breathing problems
☐ Sickle Cell Disease
☐ Hemophilia
☐ Depression or Major Depression
☐ Significant Memory Loss or Dementia
☐ Schizophrenia or other psychotic disorders
☐ SUD (Substance Use Disorder)
☐ None
☐ Heart attack, heart bypass surgery, or a stent
☐ High Blood Pressure
☐ ESRD or currently on dialysis
☐ HIV/AIDS
☐ Diabetes or sugar problems
☐ Eating Disorder
☐ Bi-Polar Disorder
☐ Anxiety Disorder
☐ Intellectual/Developmental Disability
☐ Other Condition
(please write specific issue):_____

6. Are you or anyone in your family pregnant now? ☐ **No** ☐ **Yes:**
If "yes," please provide the following information, include yourself if it applies:

Name: _____ Date of birth: _____ Due date: _____
Name: _____ Date of birth: _____ Due date: _____
Name: _____ Date of birth: _____ Due date: _____

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