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):<br>1. _____<br>2. _____<br>3. _____<br>4. _____ | Date of Birth of Adult(s):<br>1. _____<br>2. _____<br>3. _____<br>4. _____ | Medicaid #:<br>1. _____<br>2. _____<br>3. _____<br>4. _____ |
| Name of Child(ren):<br>1. _____<br>2. _____<br>3. _____<br>4. _____<br>5. _____ | Date of Birth of Child(ren):<br>1. _____<br>2. _____<br>3. _____<br>4. _____<br>5. _____ | Medicaid #:<br>1. _____<br>2. _____<br>3. _____<br>4. _____<br>5. _____ |

| 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.** 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: | ● For what problem? |
|---|---|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |

**2.** 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: | ● For what problem? |
|---|---|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |

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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**3.** Do you have a Primary Care Provider? (Example: OB/GYN or Family Medicine) ☐ **No** ☐ **Yes:**
Name of your Doctor: _____

Have you ever been told you have one or more of the following medical conditions? ☐ **No** ☐ **Yes:**
Please check the box(es) for the problem(s) that apply:

☐ 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):

**4.** Do your child(ren) have a Primary Care Provider? (Example: Pediatrician) ☐ **No** ☐ **Yes:**
Name of your child's Doctor: _____

Does he/she see this doctor 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
☐ Sickle Cell Disease
☐ None
☐ Asthma
☐ Hemophilia
☐ Other Condition (please write specific issue):
☐ Diabetes
☐ SUD (Substance Use Disorder)

**5.** Are each of your children up to date with all of their shots? ☐ **No** ☐ **Yes** ☐ **Not sure**
If "no" or "not sure," please list the names of the child(ren) who might need more shots:

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

**6.** 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. _____
2. _____
3. _____
4. _____
5. _____
6. _____

**7.** 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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