eternalHealth

AGENT NEEDS ASSESSMENT

Name: _____ Date of Birth: _____ Sex: □ Male □ Female

Stated Height: _____Feet _____inches Stated Weight: _____lbs Primary Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Is it okay to communicate with you via email? Y □ N □

Home Phone: _____ Cell: _____ Is it okay for us to text or leave voicemail? Y □ N □

GENERAL QUESTIONS:

In general, how would you rate your health? □ Excellent □ Very Good □ Good □ Fair □ Poor

Do you live alone? □ Y □ N Are you homebound? □ Y □ N Do you have a caregiver? □ Y □ N

Do you have a PCP that you see regularly? □ Y □ N If yes PCP Name: _____

Do you have a Power of Attorney (POA) or healthcare surrogate? □ Y □ N □ Not sure

How would you rate your dental Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

Dentist: _____ Last visit? _____

Do you have special DME equipment/supplies? (Walker, Oxygen, CPAP, Urinary Supplies? □ Y_____ □ N

MEDICAL HISTORY INFORMATION:

□ Chronic alcohol & other drug dependence □ Autoimmune disorders □ Cancer □ Dementia

□ Cardiovascular Disorders □ Chronic Heart Failure (CHF) □ Diabetes □ End Stage Liver Disease (ESRD)

□ Hematologic Disorders □ HIV/AIDS □ Chronic Lung Disorders □ Neurological Disorders □ Stroke

□ Chronic and disabling Mental Health Conditions □ Other: _____

MEDICATION INFORMATION: (use back for additional information)

MEDICATION NAME

Needs Assessment Completed by Agent: _____ Date: _____

If filled out by an individual other than member: Name: _____ Relationship: _____
Was member present? □ Y □ N

H Number: _____ NPN: _____ MBI: _____