Additional Notes or List of Medications

Trilogy

THI-HNA0816

Trilogy

Medical Assessment

Contact Information

First Name:____________ Last Name:____________ Date of Birth: ____________

Home Phone:____________ Cell Phone:____________ Email: ____________

☐ Please check this box to confirm that you are over 13 years of age and agree to receive emails from Trilogy.

Providers

1. Please list your primary care doctor and clinic. ____________

   If you do not have a doctor, you may choose a clinic listed in your welcome packet. Call the clinic to set up an annual physical.

2. Have you seen your doctor in the past year? ☐ Yes ☐ No

   You are covered for an annual physical and routine labs each year.

3. Do you see any specialist doctors? ☐ Yes ☐ No

   If yes, what specialists?: ____________

4. Do you see a dentist regularly? ☐ Yes ☐ No

Medical History

1. At this time how would you rate your overall health?

   Check one: ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

2. Have you visited the emergency room in the last 6 months? Yes ☐ No

   If yes, for what condition?

3. Have you been admitted to the hospital within the past year? ☐ Yes ☐ No

   If yes, for what condition? ____________

4. Do you take any medications? ☐ Yes ☐ No

   If yes, please list the names of medications on the back of this form.

5. Do you have any problems taking your medications? ☐ Yes ☐ No

   If yes, what are the problems? ____________

6. Do you follow your doctor's advice? ☐ Yes ☐ No

   If no, please tell us about the problems. ____________

Medical History

7. Do you have any heart problems such as high blood pressure, high cholesterol, chest pain or history of heart attack? ☐ Yes ☐ No
   If yes, please specify. ____________________

8. Do you remember your last blood pressure reading? ☐ Yes ☐ No
   If yes, what was it? ____________________

9. Do you have breathing problems? ☐ Yes ☐ No
   If yes, please specify. ____________________

10. Do you have diabetes or pre-diabetes? ☐ Yes ☐ No
    If yes, which type? ☐ Type 1 or ☐ Type 2

11. Has your doctor told you that you are overweight? ☐ Yes ☐ No

12. What is your current height in inches? (NOTE: 5 feet = 60 inches) ________ in.

13. What is your current weight in pounds? ________ lbs.

14. Have you ever been diagnosed with any type of cancer? ☐ Yes ☐ No
    If yes, please specify. ____________________

15. Do you have any problems with pain? ☐ Yes ☐ No
    If yes, please specify. ____________________

16. Do you have any vision or hearing problems? ☐ Yes ☐ No
    If yes, please specify. ____________________

17. Do you have any throat, stomach, bowel or liver problems? ☐ Yes ☐ No
    If yes, please specify. ____________________

18. Have you ever had a transplant? ☐ Yes ☐ No
    If yes, please specify. ____________________

19. Do you have any urgent health problems such as shortness of breath, rapid weight changes or passing out? If yes, please specify. ☐ Yes ☐ No
    ____

Behavioral Health

The following questions will be about your mental health.

1. Have you ever been diagnosed with a mental health condition (such as depression or anxiety)? ☐ Yes ☐ No
   If yes, please specify. ____________________

2. Over the past month, have you felt down or depressed? ☐ Yes ☐ No

3. Do you use your county's mental health services? ☐ Yes ☐ No

4. Do you currently drink wine, beer, or alcohol? ☐ Yes ☐ No

5. **If you said YES to #4, please answer #6, 7, 8, 9, and 10. If you said NO to #4 skip down to #11.**

6. Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No

7. Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

8. Have you felt bad or guilty about your drinking? ☐ Yes ☐ No

9. Have you ever had a drink first thing in the morning to steady your nerves, or to get rid of a hangover? ☐ Yes ☐ No

10. Do you feel that you have a problem with alcohol abuse or overuse? ☐ Yes ☐ No

11. Do you use drugs other than those required for medical reasons? ☐ Yes ☐ No
    If yes, please specify. ____________________

    If you feel you have a problem with drugs or alcohol, call your doctor about treatment.

12. Do you smoke or chew tobacco? ☐ Yes ☐ No
    If you are interested in quitting, you may call the WI Tobacco Quit Line at (800) 784-8669. It is a free service. You may also call us at any time and we can help you enroll in the program.

Basic Needs

1. Do you have any housing needs right now? ☐ Yes ☐ No

2. Do you have any problems getting to your clinic appointments or to the pharmacy? ☐ Yes ☐ No
   If yes, you may call MTM for assistance at 1-866-907-1494.

3. Do you have any concerns about having enough food for the month? ☐ Yes ☐ No

4. Do you have any urgent needs that we can help you with right now? ☐ Yes ☐ No

5. Would you like a case manager to contact you about your health concerns? ☐ Yes ☐ No