



**SOONERCARE**  
**HEALTH RISK ASSESSMENT**

Please note that this information pertains to your and /or your dependents health care.  
(One form per person)

Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_\_\_

SoonerCare ID # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_  No phone

E-mail Address: \_\_\_\_\_ Spoken Language if other than English: \_\_\_\_\_

Primary Care Physician: (PCP) \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have a medical problem that requires a specialist to be your regular doctor? Yes  No

Do you have a specialty doctor that you see? Yes  No

Name of Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you a smoker? Yes  No

Did you ever smoke? Yes  No  If yes, how many years since you stopped smoking? \_\_\_\_\_

List medical problems in order of concern:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

List all medications taken routinely, including over-the-counter and supplements. (Please list amount and frequency)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Do you have any of the following conditions? If so, please check all that apply:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> COPD               | <input type="checkbox"/> Hepatitis C              | <input type="checkbox"/> Cancer, Type: _____            |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> HIV                | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Heart Disease                  |
| <input type="checkbox"/> Kidney Failure           | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Epilepsy/seizures        | <input type="checkbox"/> Behavioral/Mental Health needs |
| <input type="checkbox"/> Evaluated for Transplant |   | <input type="checkbox"/> Transplant organ: _____  | <input type="checkbox"/> Date of transplant: _____      |

Pregnant Yes  No  If yes, Due Date: \_\_\_\_\_ Have you seen a doctor for this pregnancy? Yes  No

Who is the doctor you are seeing for this pregnancy? \_\_\_\_\_ Phone: \_\_\_\_\_

Have you been seen in the emergency room within the past 12 months?

- Yes If yes, provide reason(s) for going to the emergency room: \_\_\_\_\_
- No

Have you been in the hospital within the last 12 months?

- Yes If yes, provide reason(s) for admission to the hospital: \_\_\_\_\_
- No

If you said yes to being admitted to the hospital, did you need service coordination to enable discharge?

- Yes If yes, what services were needed: \_\_\_\_\_
- No

Are you or your child currently receiving any of the following services? (Check all that apply to you or your child)

- Area Agency       Rehabilitative       Dialysis       Chemotherapy/Radiation Therapy
- Speech Therapy       Physical Therapy       Occupational Therapy       Behavioral/Mental Health Service
- Home Health Service       Substance Abuse Service

Reason for service: \_\_\_\_\_

Provider name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of next appt: \_\_\_\_\_

Provider name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of next appt: \_\_\_\_\_

Do you need assistance scheduling any of the following?

- Transportation      Yes       No
- Making Appointments      Yes       No

Do you have any needs in the following areas?

- Hearing Aide      Yes       No
- Interpreter Services      Yes       No
- Wheelchair, scooter, walker (circle)      Yes       No
- Someone to go with you to appointments      Yes       No
- Other (please specify): \_\_\_\_\_

NONE

Do you have any of the following medical equipment or supplies?

- Wound supplies       Oxygen       Feeding Pump       Hoyer/Mechanical Lift
- Wheelchair       Specialty Bed       Breathing Machine (CPAP, BiPAP, Ventilator)
- Other: \_\_\_\_\_

Do you work with a professional within a community agency? Yes  No

Agency Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Person's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Agency Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Person's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

If no, do you feel you need help managing your health care? Yes  No

Do you receive benefits from TANF, Aid to the Needy, Blind, Disabled or respite dollars? Yes  No

Do you receive services from any other agency (WIC, Home Health Aide)? Yes  No

If yes, Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Service: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Service: \_\_\_\_\_

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Complete for your child/dependent – ages 0-17

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1. Does your child currently need or use medicine **prescribed by a doctor** (other than vitamins)?

- Yes → Go to Question 1a
- No → Go to Question 2

1a. Is this because of ANY medical, behavioral or other health condition?

- Yes → Go to Question 1b
- No → Go to Question 2

1b. Is this a condition that has lasted or is expected to last for **at least** 12 months?

- Yes
  - No
- 

2. Does your child need to use more **medical care, mental health or educational services** than is usual for most children of the same age?

- Yes → Go to Question 2a
- No → Go to Question 3

2a. Is this because of any medical, behavioral or other health condition?

- Yes → Go to Question 2b
- No → Go to Question 3

2b. Is this a condition that has lasted or is expected to last for **at least** 12 months?

- Yes
  - No
- 

3. Is your child limited or prevented in any way in his or her ability to do the things children of the same age do?

- Yes → Go to Question 3a
- No → Go to Question 4

3a. Is this because of ANY medical, behavioral or other health conditions?

- Yes → Go to Question 3b
- No → Go to Question 4

3b. Is this a condition that has lasted or is expected to last for **at least** 12 months?

- Yes
  - No
- 

4. Does your child have any kind of emotional, developmental or behavioral problem for which he or she needs or receives treatment or counseling?

- Yes → Go to Question 4a
- No

4a. Is this a condition that has lasted or is expected to last for **at least** 12 months?

- Yes
- No

Person Completing this form: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_

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Complete for Yourself – Adult 18 and older

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1. Do you currently need or use **prescription medications**? (other than vitamins or birth control pills)

- Yes → Go to Question 1a
- No → Go to Question 2

1a. Is this because of ANY medical, behavioral or other health condition?

- Yes → Go to Question 1b
- No → Go to Question 2

1b. Is this a condition that has lasted or is expected to last for **at least** 12 months?

- Yes
  - No
- 

2. Do you need to use **medical care, mental health or other health services** on a regular basis?

- Yes → Go to Question 2a
- No → Go to Question 3

2a. Is this because of ANY medical, behavioral or other health conditions?

- Yes → Go to Question 2b
- No

2b. Is this a condition that has lasted or is expected to last for **at least** 12 months?

- Yes
  - No
- 

3. Do you need or receive treatment or counseling for any kind of mental health, substance abuse or emotional problem?

- Yes → Go to Question 3a
- No

3a. Is this a condition that has lasted or is expected to last for **at least** 12 months?

- Yes
  - No
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Person that completed this form: \_\_\_\_\_ Phone: \_\_\_\_\_

Date completed: \_\_\_\_\_