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.
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.

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

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  □ 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?  □ Yes  □ No
    If yes, please specify.

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.

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.