

Road to Wellness P.O. Box 13447 Macon, GA 31208-3447 478-314-2427 or 1-800-648-7563 option 5

Email: wellness@shpg.com

Fax: 478-314-2417

## **General Status Form**

Please return this form to the address or fax number above. You can also email it to wellness@shpg.com. Name: \_\_\_\_\_ Gender: \_\_\_\_ Date: \_\_\_\_\_ Address: \_\_\_\_\_City/ST/Zip\_\_\_\_\_ Employer: Member Number: Birth Date: \_\_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ Home Ph: \_\_\_\_\_\_ Cell Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Email Address: \_\_\_\_\_ Best time to call \_\_\_\_\_ Physician: \_\_\_\_\_ Preferred Method of Contact: Home Phone Cell Phone Work Phone Email I give permission for my care manager to speak with \_\_\_\_\_ \_\_\_\_\_ about my medical condition. Please complete ALL of the following questions 1. Have you had a physician office visit for your condition at least once in the last 12 months? | Yes | No Date 2. Have you ever had an evaluation by a specialist for your chronic condition? Yes No Date 3. Have you had any inpatient hospitalizations in the last year? Yes No 4. Have you had any emergency room/urgent care visits in the last year? ☐ Yes ☐ No 5. Do you have your blood pressure checked at every physician office visit? Yes No What was your last blood pressure reading? \_\_\_\_\_ 6. Have you had a Flu Vaccination in the last 12 months? Yes No Date \_\_\_\_\_ 7. Have you had a Pneumonia Vaccination? Yes No Date\_\_\_\_\_ 8. Do you have any new medications? Yes No If yes, what? 9. Do you exercise at least 30 minutes 3 or more times a week? | Yes | No No special diet prescribed 11. Are you currently using tobacco? Yes No (Continues on back page)

12. Are you exposed to secon	na nana smoke?	Tes INO	
13. Are you drinking 6 to 8 gl	lasses of water a da	ay (if allowed by your	physician)?
Yes No Not	allowed by MD		
14. How motivated are you t motivated and 5 being m			_
15. Does your current health  Yes No? If yes, i			
16. Would you like more edu what you would be intere		on on your condition?	If so, please specify
17. What health goal would	you like to achieve	before our next conta	act?
Please list all medications you  Medication	are currently takin	ng. Be sure to include How often	over the counter meds: Condition treated
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_	-	_	
Please list all medications you Medication	-	_	

\*\*\*\*All medical information will be kept confidential in accordance with HIPAA

Thank you for taking the time to complete this questionnaire. We wish you continued success on your Road to Wellness!