BCN Advantage℠ HMO
BCN Advantage℠ HMO-POS
Blue Care Network of Michigan
Medicare and more

Patient Assessment Form

Thank you for completing this form. It will help us provide the best care for you during this visit. We hope you will also complete the annual Medicare Advantage Health Assessment form you receive by mail from BCN Advantage.

Patient information						
Patient name				**Date of birth**	**Today's date**	
Form completed by				**Relationship**		
Please answer all questions						
1	Compared to 3 to 6 months ago, how would you rate your general physical health?	Much better ☐	Slightly better ☐	About the same ☐	Slightly worse ☐	Much worse ☐
2	Does your health limit your activities, such as pushing a vacuum cleaner, climbing steps or making meals?	None of the time ☐	A little of the time ☐	Some of the time ☐	Most of the time ☐	All of the time ☐
3	Do you have difficulty doing daily activities such as bathing, dressing, eating, getting in or out of chairs, walking and/or using the toilet?	None of the time ☐	A little of the time ☐	Some of the time ☐	Most of the time ☐	All of the time ☐
4	Do you find yourself grabbing furniture or the wall to help you walk?	None of the time ☐	A little of the time ☐	Some of the time ☐	Most of the time ☐	All of the time ☐
5	Do you have trouble doing errands alone, such as visiting a doctor's office or shopping?	None of the time ☐	A little of the time ☐	Some of the time ☐	Most of the time ☐	All of the time ☐

6	A fall is when your body goes to the ground without being pushed. In the past 1 to 3 months, have you fallen?	No ☐				Yes ☐
7	Many people experience problems with urinary incontinence, which is the leakage of urine. In the past 2 months, have you accidentally leaked urine?	No ☐				Yes ☐
8	Compared to 3 to 6 months ago, how would you rate your emotional health?	I feel happy ☐	I feel a little better ☐	I feel about the same ☐	I feel a little down ☐	I feel upset ☐
9	How much of the time during the past 4 weeks have you felt downhearted or blue?	None of the time ☐	A little of the time ☐	Some of the time ☐	Most of the time ☐	All of the time ☐
10	Do you have trouble concentrating, remembering or making decisions?	None of the time ☐	A little of the time ☐	Some of the time ☐	Most of the time ☐	All of the time ☐

Office staff

1. Highlight any questions that the patient either did not address at all or answered with a response on the right side of the answer spectrum. The physician may want to address those with the patient.
2. Consider saving this form in the patient's medical record.