Initial Health Assessment (IHA)

Tel: 1-877-843-2259

Complete your Initial Health Assessment (IHA) here.

If joining our One Medical program, be sure to (1) complete and submit this form and (2) visit this One Medical activation website. Copies of your submission WILL NOT be cached, stored, or saved on this server.

Name

Member ID	**What is your current height?**	**What is your current weight?**	**Date of Birth**
Applicable only to current members.	Measurements in Ft/In	Weight in the lbs	MM/DD/YYYY

In general, would you say your health is:

☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

When was the last time you saw your primary care doctor?

☐ Less than 6 months ago ☐ 6-12 months ago ☐ More than a year ago

Have you had 3 or more emergency room (ER) visits in the last 12 months?

☐ Yes ☐ No

Have you been hospitalized 2 or more times in the past 12 months?

☐ Yes ☐ No

In the past 4 weeks, have you been feeling down, hopeless, or have little interest in doing things?

☐ Yes ☐ No

Do you need help to get around inside or outside the home?

☐ Yes ☐ No

Do you use a cane, wheelchair, or walker?

☐ Yes ☐ No

Have you fallen 2 or more times in the last 12 months?

☐ Yes ☐ No

Do you currently drink wine, beer, or other alcoholic beverages on a daily basis?

☐ Yes ☐ No

Do you smoke cigarettes, use tobacco, or any nicotine products currently or in the last 6 months?

☐ Yes ☐ No

What health conditions do you have currently, or had in the past?

☐ Allergies
☐ Bowel and Gastrointestinal Conditions
☐ Colds and Flu
☐ Diabetes
☐ Down Syndrome, Autism and Developmental Delays
☐ Fatigue and Sleep
☐ Hepatitis
☐ Infectious Diseases
☐ Kidneys
☐ Multiple Sclerosis (MS)
☐ Skin, Nails and Rashes
☐ None
☐ Asthma
☐ Cancer
☐ COPD (Chronic Obstructive Pulmonary Disease)
☐ Disease and Disease Prevention
☐ Epilepsy
☐ Heart Health and Stroke
☐ HIV
☐ Joints and Spinal Conditions
☐ Lungs and Respiratory Conditions
☐ Obesity
☐ Thyroid
☐ Other

Have you ever had surgery or any medical procedures? If yes, please specify:

☐ Yes ☐ No

Are you currently taking any medications or supplements? If yes, please specify:

☐ Yes ☐ No

Are you filling this out for yourself or a dependent on your health insurance plan?

☐ Myself

☐ My Dependent

Consent

☐ I hereby certify that, to the best of my knowledge, the provided information is true and accurate.

Best Email

An email confirmation of your submission will be sent to this email address.

Signature