Healthcare Profile

UNITE HERE HEALTH | CARE COORDINATORS BY QUANTUM HEALTH

The short health survey below and the primary doctor form (on back) can also be completed online at www.uhh.org or by calling your Care Coordinators at (866) 686-0003.

Part 1 – Short Health Survey *(Confidential)*

Employees and covered spouses (optional) should complete the list on the right. It will **NOT** be shared with your employer and will **NOT** be used to determine eligibility for benefits.

Employee Name:

Employee Date of Birth:

Employee Email:

Employee Telephone Number:

Spouse Email:

Spouse Telephone Number:

Best time of day for Care Coordinators to contact you if necessary (*check all that apply*):

- ☐ Morning (8:30 a.m. – 12:00 p.m. EST)
- ☐ Afternoon (12:00 p.m. – 4:30 p.m. EST)
- ☐ Evening (4:30 p.m. – 10:00 p.m. EST)

This Healthcare Profile is voluntary and confidential. Only certain UNITE HERE HEALTH (UHH) staff and vendors offering additional help to participants may have access to information about your medical history, smoking history, prescription drug usage, and overall health. No one else, including your employer and union, will have access to this or any other personal health information you provide. UHH may use your information to better understand the overall health needs of our participants. (Your notice of privacy practices has more information about how UHH keeps your information private.)

Return the completed form to: UNITE HERE HEALTH, P. O. Box 6557, Aurora, IL 60598-0557

Check all that apply

1. Medical Conditions	Employee	Spouse *(optional)*
Asthma	☐	☐
Diabetes	☐	☐
Depression	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Lung Disease	☐	☐
-On Oxygen	☐	☐
Multiple Sclerosis (MS)	☐	☐
-Currently Taking Injectable Medication	☐	☐
Pregnancy	☐	☐

2. Currently Under the Care of		
Heart Specialist	☐	☐
Kidney Specialist	☐	☐
-On Dialysis	☐	☐

3. General Health		
Currently Have a Case Manager	☐	☐
Use Tobacco Products	☐	☐
Had a Transplant in the Past 5 Years	☐	☐
-Type of Transplant (Employee)		
-Type of Transplant (Spouse)		
Awaiting a Transplant	☐	☐
Treated for Cancer in the Past 12 Months	☐	☐
Surgery/Procedure Scheduled in the Next 3 Months	☐	☐

None of the Above Sections Apply ☐ ☐

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Confidential

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Part 2 – Primary Doctor Form

A Primary Doctor can be a family doctor, a general practitioner, an internal medicine doctor, a pediatrician (for children), or an OB/GYN (during pregnancy). Please complete all the information below for you and all family members who are covered under your healthcare plan (please print clearly). If you or your family member is not a current patient of the Primary Doctor you list, you must make sure that the Primary Doctor listed is taking new patients at this time.

Employee Name:______________________________ Primary Doctor Address:____
Primary Doctor Name:_________________________ Primary Doctor City/State/Zip:______________________________________
____ Primary Doctor Phone Number:_______________________________________

Spouse Name:________________________________ Primary Doctor Address:____
Primary Doctor Name:_________________________ Primary Doctor City/State/Zip:______________________________________
____ Primary Doctor Phone Number:_______________________________________

Dependent Name:_____________________________ Primary Doctor Address:____
Primary Doctor Name:_________________________ Primary Doctor City/State/Zip:______________________________________
____ Primary Doctor Phone Number:_______________________________________

Dependent Name:_____________________________ Primary Doctor Address:____
Primary Doctor Name:_________________________ Primary Doctor City/State/Zip:______________________________________
____ Primary Doctor Phone Number:_______________________________________

Dependent Name:_____________________________ Primary Doctor Address:____
Primary Doctor Name:_________________________ Primary Doctor City/State/Zip:______________________________________
____ Primary Doctor Phone Number:_______________________________________

Dependent Name:_____________________________ Primary Doctor Address:____
Primary Doctor Name:_________________________ Primary Doctor City/State/Zip:______________________________________
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Primary Doctor Name:_________________________ Primary Doctor City/State/Zip:______________________________________
____ Primary Doctor Phone Number:_______________________________________

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____ Primary Doctor Phone Number:_______________________________________

Dependent Name:_____________________________ Primary Doctor Address:____
Primary Doctor Name:_________________________ Primary Doctor City/State/Zip:______________________________________
____ Primary Doctor Phone Number:_______________________________________

Dependent Name:_____________________________ Primary Doctor Address:____
Primary Doctor Name:_________________________ Primary Doctor City/State/Zip:______________________________________
____ Primary Doctor Phone Number:_______________________________________

Return the completed form to UNITE HERE HEALTH, P. O. Box 6557, Aurora, IL 60598-0557.