



NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

MARKING INSTRUCTIONS

DO NOT FOLD.



USE NO 2 PENCIL ONLY.

Complete each question as best you can, by marking the best response. This Health Risk Appraisal is not designed for people who already have Heart disease, Cancer, Kidney disease, or other serious conditions.

Your results will be kept strictly confidential.

1 SOCIAL SECURITY #
2 SEX
3 AGE (At last birthday)
4 Are you pregnant?
5 HEIGHT (without shoes)
6 WEIGHT (without shoes)

7 What is your blood pressure now?
8 What is your total cholesterol level?
9 What is your HDL cholesterol level?

PLEASE DO NOT WRITE IN THIS AREA



Turn the page.

10

CIGARETTE SMOKING

How would you describe your cigarette smoking habits?

- Still smoke → Go to question 11
- Used to smoke → Go to question 12
- Never smoked → Go to question 13

11

STILL SMOKE

cigarettes per day	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>

(Go to question 13)

12

USED TO SMOKE

Years	<input type="radio"/>	<input type="radio"/>	What was the average number of cigarettes per day that you smoked in the 2 years before you quit?
How many years has it been since you smoked cigarettes on a fairly regular basis?	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	
			<input type="radio"/> less than 9
			<input type="radio"/> 10-15
			<input type="radio"/> 16-19
			<input type="radio"/> 20+

13

Do you smoke...

pipes?	<input type="radio"/> Yes	<input type="radio"/> No
cigars?	<input type="radio"/> Yes	<input type="radio"/> No
smokeless tobacco?	<input type="radio"/> Yes	<input type="radio"/> No

14

How often do you use drugs or medication (including prescription drugs) which affect your mood or help you to relax?

- Almost every day
- Sometimes
- Rarely or never

15

Drinks

How many drinks of alcoholic beverages do you have in a typical week? (one drink = one beer, glass of wine, shot of liquor or mixed drink)	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>

16

Times last month

How many times in the last month did you drive or ride when the driver had perhaps too much to drink?	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>

17

In the next 12 months how many thousands of miles will you probably drive or ride in each of the following?

- | | |
|--|---|
| A. Car, truck, van or SUV | B. Motorcycle |
| <input type="radio"/> less than 2,000 miles | <input type="radio"/> less than 1,000 miles |
| <input type="radio"/> 2-5,000 miles | <input type="radio"/> 1,000 miles |
| <input type="radio"/> 6-10,000 miles | <input type="radio"/> 2,000 miles |
| <input type="radio"/> 11-15,000 miles | <input type="radio"/> 3,000 miles |
| <input type="radio"/> 16-20,000 miles | <input type="radio"/> 4,000 miles |
| <input type="radio"/> 21-30,000 miles | <input type="radio"/> more than 4,000 miles |
| <input type="radio"/> more than 30,000 miles | <input type="radio"/> does not apply |
| <input type="radio"/> does not apply | |

18

What percent of the time do you usually buckle your safety belt when driving or riding?

- 100%
- 90-99%
- 80-89%
- less than 80%

19

On the average, how close to the speed limit do you usually drive?

- Within 5 mph of the speed limit
- 6-10 mph over the limit
- More than 10 mph over the limit

20

On a typical day, how do you usually travel? (mark only one)

- Sub-compact or compact car
- Mid-size or full-size car, or minivan
- Truck, van, full-size van or SUV
- Motorcycle
- Other

21

How many servings of food do you eat that are high in fiber, such as whole grain bread, high fiber cereal, fresh fruits or vegetables? (serving size: 1 slice bread, ½ c vegetables, 1 medium fruit, ¾ c cereal)

- 5-6 servings a day
- 3-4 servings a day
- 1-2 servings a day
- Rarely / never

22

How many servings of food do you eat that are high in cholesterol or fat such as fatty meat, cheese, fried foods or eggs? (serving size: 3 ½ oz meat, 1 egg, 1 oz/slice cheese)

- 5-6 servings a day
- 3-4 servings a day
- 1-2 servings a day
- Rarely / never

23

In the average week, how many times do you engage in physical activity (exercise or work which is hard enough to make you breathe heavily and make your heart beat faster) and is done for at least 20 minutes? Examples include running, brisk walking or heavy labor, chopping, lifting, digging, etc.

- Less than 1 time per week
- 1 or 2 times per week
- 3 times per week
- 4 or more times per week

Turn the page. 



24 In general, how satisfied are you with your life (include personal and professional aspects)?

- Completely satisfied
- Partly satisfied
- Mostly satisfied
- Not satisfied

25 Would you agree you are satisfied with your job?

- Agree strongly
- Disagree
- Agree
- Disagree strongly

26 In general, how strong are your social ties with your family and/or friends?

- Very strong
- Weaker than average
- About average
- Not sure

27 Considering your age, how would you describe your overall physical health?

- Excellent
- Good
- Poor
- Very Good
- Fair

28 How many hours of sleep do you usually get at night?

- 6 hours or less
- 8 hours
- 7 hours
- 9 hours or more

29 Have you suffered a personal loss or misfortune in the past year? (For example: a job loss, disability, divorce, separation, jail term, or the death of someone close to you)

- Yes, two or more serious losses
- Yes, one serious loss
- No

30 How often do you feel tense, anxious, or depressed?

- Often
- Rarely
- Sometimes
- Never

31 During the past year, how much effect has stress had on your health?

- A lot
- Some
- Hardly any
- None

32 In the past year, how many days of work have you missed due to personal illness?

- 0
- 3-5 days
- 11-15 days
- 1-2 days
- 6-10 days
- 16 days or more



33 During the past 4 weeks how much did your health problems affect your productivity while you were working?

- no health problems some of the time all of the time
 none of the time most of the time

34 How many hours did you take off from work over the past 2 weeks to take care of sick children, parents or other relatives? (This might include taking children to doctor's appointments, staying home with a sick child or parent or calling doctors or health insurance companies.)

Hours

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

35 Do you have a family history (brother, sister, mother, father, grandparents) of:

- | | | | | | | |
|---------------------|-----------------------|-----|-----------------------|----|-----------------------|--------------|
| High Blood Pressure | <input type="radio"/> | Yes | <input type="radio"/> | No | <input type="radio"/> | I'm not sure |
| Heart Problems | <input type="radio"/> | Yes | <input type="radio"/> | No | <input type="radio"/> | I'm not sure |
| Diabetes | <input type="radio"/> | Yes | <input type="radio"/> | No | <input type="radio"/> | I'm not sure |
| Cancer | <input type="radio"/> | Yes | <input type="radio"/> | No | <input type="radio"/> | I'm not sure |
| High Cholesterol | <input type="radio"/> | Yes | <input type="radio"/> | No | <input type="radio"/> | I'm not sure |

36

Do you have:		never	in the past	may currently	If have currently	
					taking medication	under medical care
Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Back Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic bronchitis/ emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heartburn or acid reflux	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menopause	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraine headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other condition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

37

When was the last time you had these preventive services or health screenings?

	less than 1 year	1-2 years ago	2-3 years ago	3-4 years ago	5-6 years ago	7 or more years ago	Never	Don't know
Colon cancer screen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rectal exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Flu shot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tetanus shot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For Women Only

Pap Test	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mammogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast exam by Physician or nurse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For Men Only

Prostate exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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38

In the past 12 months, how many times have you:

	0	1-2	3-5	6 or more
Visited a physician's office or clinic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gone to the emergency room	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stayed overnight in a hospital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Used a 1-800 number for medical advice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Used a self-care book	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been treated with alternative medicine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WOMEN (Men go to question 44)

39

How many women in your natural family (mother and sisters only) have had breast cancer?

- None
- 1
- 2 or more
- Don't know

40

Have you had a hysterectomy operation?

- Yes
- No
- I'm not sure

41

At what age did you have your first menstrual period?

- Younger than 12
- 12
- 13
- 14 or older

- 42** How old were you when your first child was born?
- Younger than 20
 - 20 to 24
 - 25 to 29
 - 30 or older
 - Does not apply

- 43** How often do you examine your breasts for lumps?
- Monthly
 - Once every few months
 - Rarely or never

MEN (Women go to question 45)

- 44** How often do you examine your testicles for lumps?
- Monthly
 - Once every few months
 - Rarely or never

- 45**
- Single (never married)
 - Separated
 - Divorced
 - Married
 - Widowed
 - Other

- 46**
- White (non-Hispanic origin)
 - Black (non-Hispanic origin)
 - Hispanic
 - Asian or Pacific Islander
 - American Indian / Alaskan Native
 - Other

- 47**
- Some high school or less
 - High school graduate
 - Some college
 - College graduate
 - Post graduate or professional degree

- 48**
- less than \$35,000
 - \$35,000 - \$49,999
 - \$50,000 - \$74,999
 - \$75,000 - \$99,999
 - \$100,000 or more



Turn the page.



49

In the next 6 months, are you planning to make any changes to keep yourself healthy or improve your health?

	Yes	No	Don't Know	Not Needed
Increase physical activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lose weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reduce alcohol use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quit or cut down smoking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reduce fat / cholesterol intake	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lower blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lower cholesterol level	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cope better with stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

50

In the next 6 months, would you participate in a program that would help you to enhance your overall health?

Yes No I'm not sure

51

If available would you like follow up information and other services?

Yes No I'm not sure

THANK YOU FOR YOUR PARTICIPATION.

PLEASE DO NOT WRITE IN THIS AREA

