Health Risk Assessment

Please complete the survey below.

Thank you!

1) First Name:

_____

2) Last Name:

_____

3) Birth Date (mm/dd/yyyy): _____

4) Age: _____

5) Gender:

◯ male ◯ female

6) Health View

Mark any of the following that apply to you:

☐ I'm as healthy as anybody I know.
☐ I seem to get sick a little easier than other people.
☐ I expect my health to get worse.
☐ I have a serious health problem.

7) General Health.

Complete the following statement: "In general, my overall health is..."

◯ excellent
◯ very good
◯ good
◯ fair
◯ poor

8) Family Health History

Select any of the following health problems found in your family (parent, brother, sister).

☐ sudden death at a young age (teens, 20's, 30's)
☐ sudden infant death syndrome (unexplained infant death under 1 year of age)
☐ arrhythmia (fast or funny heart beats)
☐ congenital heart disease
☐ colorectal cancer
☐ breast cancer
☐ diabetes
☐ coronary heart disease, heart attack, or coronary surgery before age 55 in men, before age 65 in women.
☐ high blood pressure
☐ high cholesterol

Personal Health History

Has a doctor informed you that you currently have any of the following health problems?

Check the appropriate responses.

9) asthma

◯ No personal history ◯ Yes, but not taking medication ◯ Yes, and taking medication

10) diabetes (high blood sugar)

◯ No personal history ◯ Yes, but not taking medication ◯ Yes, and taking medication

11) high blood pressure (140/90 or higher)

◯ No personal history ◯ Yes, but not taking medication ◯ Yes, and taking medication

12) high blood cholesterol (240 or higher)

◯ No personal history ◯ Yes, but not taking medication ◯ Yes, and taking medication

To what extent have you been limited in the following activities

13) Climbing several flights of stairs

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, not limited at all

14) Walking several blocks

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, not limited at all

15) Lifting or carrying groceries or other objects

◯ Yes, limited a lot ◯ Yes, limited a little ◯ No, not limited at all

16) Exercise.

How many days per week do you engage in aerobic exercise of at least 20 to 30 minutes duration (fitness walking, cycling, jogging, swimming, aerobic dance, or active sports)?

◯ no exercise program
◯ one day per week
◯ two days per week
◯ three days per week
◯ four days per week
◯ five days per week
◯ six days per week
◯ seven days per week

17) Strength Exercises.

How many times per week do you do strength-building exercised such as sit-ups, push-ups, or use weight training equipment?

◯ none
◯ once a week
◯ twice a week
◯ three or more times a week

18) Stretching Exercises.

How many times per week do you do stretching exercises to improve the flexibility of your back, neck, shoulders, and legs?

◯ none
◯ once a week
◯ twice a week
◯ three or more times a week

19) Breakfast.

How often do you eat breakfast, more than just a roll and cup of coffee?

◯ seldom or never eat breakfast
◯ eat breakfast two to three times per week
◯ eat breakfast most mornings
◯ eat breakfast every day

20) Snacks.

How often do you eat snack foods between meals (chips, pastries, soft drinks, candy, ice cream, cookies)?

- ◯ seldom or never eat typical snacks
- ◯ few times per week
- ◯ once or twice per day
- ◯ three or more times per day

21) Salt.

How often do you add salt to your food or eat salty foods (chips, pickles, soy sauce)?

- ◯ seldom or never
- ◯ some meals
- ◯ most meals
- ◯ nearly every meal

22) Fat Intake.

Indicate the kinds of foods you usually eat (see list below for examples)

- ◯ nearly always eat the high-fat foods
- ◯ eat mostly the high-fat foods, some low-fat
- ◯ eat both about the same
- ◯ eat mostly low-fat foods, some high-fat
- ◯ eat only low-fat foods

Fat Intake

High-Fat Examples:

- hamburgers
- hot dogs
- bologna
- steaks
- sour cream
- cheese
- whole milk
- eggs
- butter
- cake
- pastry
- ice cream
- chocolate
- fried foods
- many fast foods

Low-Fat Examples:

- lean meats
- skinless poultry
- fish
- skim milk

- low-fat dairy products

- fruit desserts

- gelatin

- vegetables

- pasta

- legumes (peas and beans)

23) Breads and Grains.

Indicate the kinds of breads and grains you usually eat (see list below for examples).

- ◯ nearly always eat refined grain products
- ◯ eat mostly refined grain products, some whole-grain
- ◯ eat both about the same
- ◯ eat primarily whole-grain products, some refined
- ◯ eat only whole-grain products

Breads and Grains.

Refined Grain Examples:

- white bread

- white rolls

- regular pancakes and waffles

- white rice

- typical breakfast cereals

- typical baked goods

Whole-Gran Examples:

- whole-grain breads

- brown rice

- oatmeal and many other cooked cereals

- whole-grain or high-fiber cereals

24) Fruits and Vegetables.

How many servings of fruits and vegetables to you eat daily?

- ◯ one or less
- ◯ two daily
- ◯ three daily
- ◯ four daily
- ◯ five or more

25) Number of Drinks.

How many alcoholic drinks do you usually have per week?

(One drink - a 12 oz beer or wine cooler, 5 oz. wine, or 1.5 oz. distilled liquor.)

- ◯ seldom or never
- ◯ one to seven
- ◯ eight to 14
- ◯ 15 to 20
- ◯ 21 or more

26) Medications.

How often do you use drugs or medications (including prescription and nonprescription) that affect your mood, help you relax, or help you sleep?

- ◯ frequently, every week
- ◯ sometimes, once or twice a month
- ◯ rarely, a few times per year
- ◯ never

27) Smoking Status.

Select the appropriate response.

- ◯ have never smoked
- ◯ quit smoking two or more years ago
- ◯ quit smoking less than two years ago
- ◯ currently smoke pipe or cigar only
- ◯ currently smoke less than 10 cigarettes daily
- ◯ currently smoke 10 or more cigarettes daily

28) Chewing Tobacco.

Do you use chewing tobacco?

- ◯ yes
- ◯ no

29) Coping Status.

How well do you feel you are coping with your current stress load?

- ◯ coping very well
- ◯ coping fairly well
- ◯ have trouble coping at times
- ◯ often have trouble coping
- ◯ feel unable to cope

30) Stress Signals.

Select any item that applies to you.

- ☐ Minor problems throw me for a loop.
- ☐ I find it difficult to get along with people.
- ☐ Nothing seems to give me pleasure anymore.
- ☐ I am unable to stop thinking about my problems.
- ☐ I feel frustrated, impatient, or angry much of the time.
- ☐ I feel tense or anxious much of the time.

31) Sleep.

On the average, how often do you get at least 7 to 8 hours of sleep each day?

- ◯ always or nearly always
- ◯ most of the time
- ◯ less than half the time
- ◯ seldom or never

32) Social Support.

Do you have friends/family with whom you can share problems or from whom you can get help if needed?

- ◯ no
- ◯ yes

33) Sick Days.

How many days did you miss from school or work due to illness or injury during the past 12 months?

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10 or more