ConnectionPAD Health Assessment

socialWellth
Health, the Wealth that Matters.

What is a Health Assessment? It's a quick check of your health habits and risk factors. After answering a series of questions, you'll get your Health Age and a results summary. You'll find out which health and lifestyle factors are making you older – or younger – than your actual age.

Is it right for me? Yes! If you're concerned about your health, the Health Assessment is tailor-made for you. You will get great tips and info on how to improve your health.

What do I need to do? Invest about 15 minutes answering some simple, but important, health questions. We'll ask about you, your health background and conditions, what you eat and drink, your lifestyle habits, and your measurements (like weight and blood pressure). It's okay if you don't know all the answers, but honest and correct information will help us provide the most accurate Health Age and results.

Privacy:
We are required by law to maintain the privacy of your Protected Health Information (PHI) and abide by the terms of this notice as stated in the Federal Health Insurance Portability and Accountability Act (or HIPAA) Privacy Rule.

We protect your privacy by:

- Limiting who may see your PHI,
- Limiting how we may use or disclose your PHI,
- Informing you of our legal duties with respect to your PHI,
- Explaining our privacy policies, and
- Adhering to the policies currently in effect.

Privacy Policy:
You can retrieve a printed copy of our privacy policy by going to http://connectionpad.com and clicking the privacy statement link at the bottom of the page.

You also have the right to request a paper copy of any privacy policies or your personal record at any time. For information about how to obtain a copy of and receive answers to questions, please contact us via e-mail at info@socialwellth.com or call 702-821-0818. You may also request a copy by writing to the following address:
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Review Process: Personal health tools are reviewed at least annually. They are reviewed more frequently if needed or if dictated by the guidelines in our Standard Operating Procedure for Updating Evidence. Updates are made as a result of these reviews, and also on an as-needed basis as we receive feedback from customers and participants and/or conduct user acceptance testing.

Disclaimer: This information is neither intended nor implied to be a substitute for professional medical advice, nor is it intended to be used for medical diagnosis, treatment or for emergency health situations. The service is presented for the sole purpose of disseminating health information. It is not intended and must not be taken to be the provision or practice of medical, nursing or professional health care advice or services in any jurisdiction. Always seek the advice of your physician or other qualified health provider prior to starting any new treatment or with any questions you may have regarding a medical condition.

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Health Assessment Instructions

Please fill out the Health Assessment as completely and accurately as possible. Please write clearly and make sure your name and member number is at the bottom of each page. Once your Health Assessment is complete, please return to **<enter appropriate person i.e.) HR or wellness or employer>.** The results of your Health Assessment will be mailed to you and will also be saved in your personal ConnectionPAD account.

About You

Let's start by getting some basic information about who you are.

MEMBER ID:		
FIRST NAME:	**LAST NAME:**	
MAILING ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
E-MAIL ADDRESS:		
CELL PHONE:		

WHAT IS YOUR GENDER?

- ☐ Male
- ☐ Female

WHAT IS YOUR DATE OF BIRTH?

_____/___/_____
Month/ Day / Year (xx/xx/xxxx)

WHAT IS YOUR MARITAL STATUS?

- ☐ Single (never married)
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Prefer not to answer

WHAT IS YOUR RACE/ETHNICITY?

FYI: People of certain races/ethnicities have a greater risk of developing some health conditions. Answering this question increases the accuracy of your Health Age score.

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White (non-Hispanic)
- ☐ Hispanic/Latino Ethnicity
- ☐ Other
- ☐ Prefer not to answer

Health History

Thanks for telling us a bit about yourself. Now let's focus on learning about your health.

HOW WOULD YOU RATE YOUR OVERALL HEALTH COMPARED TO OTHERS YOUR AGE?

- ☐ Poor
- ☐ Fair
- ☐ Average
- ☐ Good
- ☐ Excellent

HAVE YOU EVER BEEN TOLD YOU HAVE ANY OF THE FOLLOWING CONDITIONS? (CHOOSE ALL THAT APPLY.)

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Borderline diabetes
- ☐ Cancer
- ☐ Celiac disease
- ☐ Cervical dysplasia or abnormal Pap smear
- ☐ Chronic bronchitis or emphysema (COPD)
- ☐ Chronic kidney disease
- ☐ Chronic pain
- ☐ Congestive heart failure
- ☐ Coronary artery disease (includes angina & heart attack)
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes, type 1
- ☐ Diabetes, type 2
- ☐ Heartburn (acid reflux)
- ☐ High blood pressure (hypertension)
- ☐ High cholesterol
- ☐ Peripheral vascular disease
- ☐ Sickle cell disease
- ☐ Stroke or transient stroke (TIA)
- ☐ None of the above

IF YOU SELECTED "HIGH BLOOD PRESSURE (HYPERTENSION)," ARE YOU CURRENTLY BEING TREATED FOR YOUR HIGH BLOOD PRESSURE (HYPERTENSION)?

- ☐ Yes
- ☐ No
- ☐ I'm not sure

IF YOU SELECTED "CHRONIC PAIN," WHERE IS YOUR PAIN LOCATED? (CHOOSE ALL THAT APPLY.)

- ☐ Head
- ☐ Neck
- ☐ Arms
- ☐ Chest
- ☐ Upper back
- ☐ Lower back
- ☐ Abdominal / pelvis
- ☐ Legs
- ☐ Generalized (mostly everywhere)
- ☐ Other

IF YOU SELECTED "CANCER," WHAT TYPE OF CANCER(S) HAVE YOU BEEN DIAGNOSED WITH? (CHOOSE ALL THAT APPLY.)

- ☐ Bladder cancer
- ☐ Breast cancer (Female)
- ☐ Cervical cancer (Female)
- ☐ Colon or rectal cancer
- ☐ Lung cancer
- ☐ Ovarian cancer (Female)
- ☐ Prostate cancer (Male)
- ☐ Skin cancer
- ☐ Other

Member ID:________________________ First Name:______________________ Last Name__________________________

Have you ever had any of the following procedures? (Choose all that apply.)

- ☐ Bilateral mastectomy (Female)
- ☐ Coronary balloon angioplasty
- ☐ Coronary stent placement
- ☐ Coronary artery bypass surgery (CABG)
- ☐ Organ transplant
- ☐ Peripheral vascular procedure (bypass or stent in artery)
- ☐ Prostatectomy (prostate removal) (Male)
- ☐ Total colectomy (colon removal)
- ☐ Total hysterectomy (uterus & cervix removed)(Female)
- ☐ None of the above

If you selected "organ transplant," what type of organ transplant did you have? (Choose all that apply.)

- ☐ Bone marrow
- ☐ Heart
- ☐ Kidney
- ☐ Liver
- ☐ Lung
- ☐ Other

If you selected "peripheral vascular procedure," what was the reason for your procedure?

- ☐ Blockage or narrowing of carotid (neck) vessel
- ☐ Blockage or narrowing of leg vessel
- ☐ Other

Do you take any of the following medications or supplements regularly? (Choose all that apply.)

- ☐ Allergy remedy (e.g. Claritin, Dimetapp, Benadryl)
- ☐ Aspirin (daily low dose to prevent heart attack or stroke)
- ☐ Calcium supplement
- ☐ Herbal or botanical supplements
- ☐ Folate
- ☐ Iron
- ☐ Multi-vitamin
- ☐ Prenatal vitamin (Female, Age 18-52)
- ☐ Sleeping pills
- ☐ None of the above

Females, age 18-52 - Are you currently pregnant or planning to become pregnant within the next 12 months?

- ☐ No
- ☐ Yes, currently pregnant
- ☐ Yes, planning to become pregnant

Females, age 18-52 - If you selected "currently pregnant," what is your expected delivery date?

_____/___/_____
Month/ Day / Year (xx/xx/xxxx)

Females, age 50-75 - Are you currently taking hormone therapy (HT)?

- ☐ Yes
- ☐ No

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FEMALES, AGE 50-75 - IF YOU ANSWERED "YES" TO HT, SELECT THE STATEMENT THAT DESCRIBES THE HT YOU ARE RECEIVING:

- ☐ I have been receiving HT with e**strogen and progesterone** for 5 years or more.
- ☐ I have been receiving HT with e**strogen (only)** for 5 years or more.
- ☐ I have been receiving HT for less than 5 years.
- ☐ None of the above

Optional - Family Health History

FYI: THE GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008 PUTS LIMITS ON HOW HEALTH PLANS AND EMPLOYERS CAN COLLECT AND USE GENETIC INFORMATION, INCLUDING FAMILY HEALTH HISTORY. THE LAW ALLOWS FOR THE COLLECTION OF FAMILY HISTORY INFORMATION IN VOLUNTARY WELLNESS PROGRAMS.

TO YOUR KNOWLEDGE, HAVE ANY OF YOUR IMMEDIATE FAMILY MEMBERS (MOTHER, FATHER, BROTHER, OR SISTER) HAD ANY OF THE FOLLOWING CONDITIONS? (CHOOSE ALL THAT APPLY.)

- ☐ Breast cancer (Female)
- ☐ Colon cancer or colon polyps
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease (father/brother) under the age of 55
- ☐ Heart disease (mother/sister) under the age of 65
- ☐ High blood pressure (hypertension)
- ☐ Prostate cancer (Male)
- ☐ Skin cancer
- ☐ Stroke
- ☐ None of the above

Measurements

Thanks for telling us about your health. Now we have a few questions about your measurements.

HOW TALL ARE YOU?

______FT. _____IN.

HOW MUCH DO YOU WEIGH?

_______LBS.

WHAT IS YOUR WAIST CIRCUMFERENCE?

FYI: TO MEASURE YOUR WAIST CIRCUMFERENCE, PLACE A TAPE MEASURE AROUND YOUR BELLY JUST ABOVE YOUR HIPBONE. BE SURE THAT THE TAPE IS SNUG. RELAX, EXHALE, AND MEASURE YOUR WAIST.

_______IN.

WHAT IS YOUR BLOOD PRESSURE?

______ / ______ MMHG

- ☐ I don't know

Member ID:__________________________ First Name:________________________ Last Name____________________________

IF YOU ANSWERED "I DON'T KNOW" TO BLOOD PRESSURE, PLEASE CHOOSE AN APPROPRIATE ANSWER BELOW.

- ☐ I think my blood pressure is too high.
- ☐ I think my blood pressure is a little high.
- ☐ I think my blood pressure is OK.
- ☐ I have no idea what my blood pressure is.
- ☐ None of the above

WHEN WAS THE LAST TIME YOU HAD A LIPID PROFILE TEST (TOTAL CHOLESTEROL, HDL, LDL AND TRIGLYCERIDES)?

- ☐ Less than a year ago
- ☐ More than a year ago but less than 2 years ago
- ☐ More than 2 years ago but less than 5 years ago
- ☐ More than 5 years ago
- ☐ I'm not sure
- ☐ Never

ENTER THE LIPID LEVELS YOU KNOW (IF YOU DON'T KNOW ONE, LEAVE IT BLANK):

TOTAL CHOLESTEROL: ____/____ MG/DL ☐ I don't know
LDL: ____/____ MG/DL ☐ I don't know
HDL: ____/____ MG/DL ☐ I don't know
TRIGLYCERIDES: ____/____ MG/DL ☐ I don't know

IF YOU ANSWERED "I DON'T KNOW" TO ALL OF THE LIPID QUESTIONS, WHICH OF THESE STATEMENTS BEST DESCRIBES YOUR LIPID LEVELS?

- ☐ I'm taking medication for my lipids, but my levels are still too high.
- ☐ I'm taking medication for my lipids, and my levels are normal.
- ☐ I've been told that my lipid levels are high, but I'm not taking medication for it.
- ☐ I've been able to bring my lipid levels down into normal range with lifestyle changes.
- ☐ I think my lipid levels have always been OK.
- ☐ I have no idea what my lipid levels are.
- ☐ None of the above

HAVE YOU HAD YOUR FASTING BLOOD SUGAR CHECKED WITHIN THE LAST 12 MONTHS?

FYI: A FASTING BLOOD SUGAR LEVEL IS A TEST USED TO HELP DETERMINE YOUR RISK OF DEVELOPING DIABETES, PRE-DIABETES, AND METABOLIC SYNDROME. YOU ARE USUALLY TOLD NOT TO EAT OR DRINK FOR AT LEAST 8 HOURS BEFORE THE TEST.

- ☐ Yes, and I know my level
- ☐ Yes, but I don't know my level
- ☐ No

IF YOU ANSWERED "YES, AND I KNOW MY LEVEL" TO THE BLOOD SUGAR QUESTION, ENTER YOUR FASTING BLOOD SUGAR.

____/____ MG/DL

IF YOU HAVE DIABETES (BORDERLINE, TYPE 1, OR TYPE 2), PLEASE ANSWER THE FOLLOWING 5 QUESTIONS:

HAVE YOU HAD YOUR A1C CHECKED WITHIN THE LAST 6 MONTHS?

FYI: A1C IS A TEST USED TO MEASURE HOW WELL YOUR BLOOD SUGAR HAS BEEN MANAGED OVER THE LAST 2-3 MONTHS.

- ☐ Yes, and I know my level
- ☐ Yes, but I don't know my level
- ☐ No

Member ID:________________________ First Name:______________________ Last Name__________________________

If you answered "Yes, and I know my level" to the hemoglobin question, enter your A1c value:

_________%

Have you had a microalbumin (urine protein) test within the last 12 months?

FYI: Microalbumin is a urine test done to detect early signs of kidney damage in people with diabetes.

- ☐ Yes, and I know my level
- ☐ Yes, but I don't know my level
- ☐ No

If you answered "Yes, and I know my level" to the microalbumin question, were your results normal or elevated (high)?

- ☐ Normal
- ☐ Elevated (high)
- ☐ I don't know

If you answered "Yes, and I know my level" to the microalbumin question, what type of microalbumin test was performed?

- ☐ Spot Urine
- ☐ Timed Urine
- ☐ 24 HR Urine
- ☐ I don't know

Screenings & Vaccinations

Thanks for that info. Now, please tell us how recently you had each of the following screening tests and immunizations. If your doctor has advised you not to have it, please select "Not needed."

How long ago was your last doctor checkup?

FYI: This is a thorough medical exam by your doctor. It includes a physical exam and a review of your medications, vital signs and recommended health screenings. This is a good time to discuss any physical or emotional problems you are having.

- ☐ 0-1 year
- ☐ 1-2 years
- ☐ 2-3 years
- ☐ 3-5 years
- ☐ 5-10 years
- ☐ 10+ years
- ☐ I'm not sure
- ☐ Never
- ☐ Not needed

How long ago was your last eye exam?

- ☐ 0-1 year
- ☐ 1-2 years
- ☐ 2-3 years
- ☐ 3-5 years
- ☐ 5-10 years
- ☐ 10+ years
- ☐ I'm not sure
- ☐ Never
- ☐ Not needed

Member ID:________________________ First Name:______________________ Last Name__________________________

AGE ≥ 50 - HOW LONG AGO WAS YOUR LAST COLON CANCER SCREENING?

- ☐ 0-1 year
- ☐ 1-2 years
- ☐ 2-3 years
- ☐ 3-5 years
- ☐ 5-10 years
- ☐ 10+ years
- ☐ I'm not sure
- ☐ Never
- ☐ Not needed

IF YOU'VE HAD A COLON CANCER SCREENING WITHIN THE PAST 10 YEARS, WHAT TYPE OF SCREENING DID YOU HAVE?

FYI: YOUR DOCTOR WILL BE ABLE TO RECOMMEND THE BEST TYPE OF SCREENING FOR YOU. THE MOST COMMON TYPES OF COLON CANCER SCREENINGS ARE:

- *FECAL OCCULT BLOOD TEST: A STOOL SAMPLE IS SENT TO THE LAB TO LOOK FOR TRACES OF BLOOD IN THE STOOL (AN EARLY SIGN OF COLON CANCER.)*
- *SIGMOIDOSCOPY: AFTER THE BOWEL IS CLEANSED, A THIN TUBE IS INSERTED INTO THE RECTUM. THE TUBE CONTAINS A TINY CAMERA WHICH ALLOWS THE DOCTOR TO VIEW THE LOWER COLON.*
- *COLONOSCOPY: AFTER THE BOWEL IS CLEANSED, A THIN TUBE IS INSERTED INTO THE RECTUM. THE TUBE CONTAINS A TINY CAMERA WHICH ALLOWS THE DOCTOR TO VIEW THE ENTIRE LENGTH OF THE COLON. PATIENTS ARE USUALLY SEDATED BEFORE THIS PROCEDURE.*

- ☐ Fecal Occult Blood
- ☐ Sigmoidoscopy
- ☐ Colonoscopy
- ☐ Other

FEMALE AND AGE ≥ 40 - HOW LONG AGO WAS YOUR LAST BREAST CANCER SCREENING?

FYI: BREAST CANCER SCREENING CAN INCLUDE A CLINICAL BREAST EXAM OR MAMMOGRAM. DURING A CLINICAL BREAST EXAM, THE HEALTH CARE PROVIDER CAREFULLY FEELS THE BREASTS AND UNDER THE ARMS. A MAMMOGRAM IS AN X-RAY PICTURE OF THE BREASTS. IT IS USED TO SCREEN FOR BREAST CANCER AND LOOK FOR SYMPTOMS OF BREAST DISEASE.

- ☐ 0-2 years
- ☐ 2-3 years
- ☐ 3-5 years
- ☐ 5-10 years
- ☐ 10+ years
- ☐ I'm not sure
- ☐ Never
- ☐ Not needed

FEMALE - HOW LONG AGO WAS YOUR LAST PAP SMEAR?

FYI: A PAP SMEAR IS A SCREENING TEST TO LOOK FOR EARLY SIGNS OF CERVICAL CANCER.

- ☐ 0-3 years
- ☐ 3-5 years
- ☐ 5-10 years
- ☐ 10+ years
- ☐ I'm not sure
- ☐ Never
- ☐ Not needed

Member ID:________________________ First Name:______________________ Last Name__________________________

MALE, AGE ≥ 40 - HAVE YOU SPOKEN WITH YOUR DOCTOR ABOUT THE RISKS AND BENEFITS OF SCREENING FOR PROSTATE CANCER?

- ☐ Yes
- ☐ No

HAVE YOU HAD A FLU VACCINE WITHIN THE PAST YEAR?

- ☐ Yes
- ☐ No

HOW LONG AGO WAS YOUR LAST PNEUMONIA VACCINE?

- ☐ 0-1 year
- ☐ 1-2 years
- ☐ 2-3 years
- ☐ 3-5 years
- ☐ 5-10 years
- ☐ 10+ years
- ☐ I'm not sure
- ☐ Never
- ☐ Not needed

IF YOU HAVE DIABETES, HOW LONG AGO WAS YOUR LAST DIABETIC FOOT EXAM?

FYI: REGULAR DIABETIC FOOD EXAMS PERFORMED BY YOUR DOCTOR OR HEALTHCARE PROVIDER ARE PART OF GOOD DIABETES MANAGEMENT. THE EXAM SHOULD BE DONE WITH YOUR SOCKS AND SHOES OFF, AND YOUR DOCTOR SHOULD CHECK YOUR SKIN, FOOT STRUCTURE, CIRCULATION, AND SENSATION.

- ☐ 0-1 year
- ☐ 1-2 years
- ☐ 2-3 years
- ☐ 3-5 years
- ☐ 5-10 years
- ☐ 10+ years
- ☐ I'm not sure
- ☐ Never
- ☐ Not needed

Physical Activity

Now we have a couple of questions about how much exercise you're getting.

IN A TYPICAL WEEK, HOW MANY DAYS DO YOU PERFORM CARDIOVASCULAR EXERCISE OR ACTIVITY?
FYI: CARDIOVASCULAR ACTIVITY (OR AEROBIC ACTIVITY) IS EXERCISE THAT INCREASES THE HEART RATE, INCREASES THE BREATHING RATE, AND IMPROVES CIRCULATION.

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7

IF YOU EXERCISE, PLEASE ANSWER THE FOLLOWING 3 QUESTIONS.

ON THE DAYS THAT YOU DO EXERCISE, HOW MANY MINUTES PER DAY DO YOU TYPICALLY SPEND DOING THE EXERCISE OR ACTIVITY?

- ☐ 10
- ☐ 20
- ☐ 30
- ☐ 40
- ☐ 50
- ☐ 60+

AT WHAT INTENSITY LEVEL DO YOU USUALLY PERFORM THE EXERCISE OR ACTIVITY?

- ☐ Light (no major change in breathing pattern)
- ☐ Moderate (start to sweat, able to talk but not sing)
- ☐ Intense (rapid breathing, able to speak only a few words between breaths)

HOW MANY DAYS EACH WEEK DO YOU PERFORM MUSCLE STRENGTHENING EXERCISES THAT WORK ALL YOUR MAJOR MUSCLE GROUPS?
FYI: MUSCLE GROUPS INCLUDE YOUR LEGS, HIPS, BACK, ABDOMEN, CHEST, SHOULDERS, AND ARMS. SOME EXAMPLES OF STRENGTH TRAINING EXERCISES INCLUDE WEIGHTLIFTING, YOGA, PILATES, AND PUSHUPS.

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7

Member ID:________________________ First Name:______________________ Last Name__________________________

Nutrition

When thinking about the way you usually eat, please rate yourself according to the following statements.

I READ THE "NUTRITION FACTS LABEL" BEFORE BUYING FOODS AND INGREDIENTS.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

I CHOOSE FIBER-RICH FRUITS, VEGETABLES AND WHOLE GRAINS FOR MY MEALS.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

I EAT AT LEAST 2 1/2 CUPS OF A VARIETY OF VEGETABLES EACH DAY.

FYI: ONE VEGETABLE SERVING IS EQUAL TO: 1 CUP RAW LEAFY GREEN VEGETABLES; 1/2 CUP OTHER COOKED OR RAW VEGETABLE; ONE MEDIUM POTATO; OR 6 OZ VEGETABLE JUICE.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

I EAT AT LEAST 2 CUPS OF A VARIETY OF FRUITS EACH DAY.

FYI: ONE FRUIT SERVING IS EQUAL TO: 1 MEDIUM ORANGE, APPLE, BANANA OR PEAR; 12 GRAPES; 1/3 CUP CHOPPED, COOKED OR CANNED FRUIT; 1/4 CUP RAISINS; OR 6 OZ FRUIT JUICE.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

I EAT A VARIETY OF HIGH-QUALITY LEAN PROTEIN SOURCES EACH DAY (SEAFOOD, LEAN MEATS, POULTRY, EGGS, BEANS, PEAS, SOY PRODUCTS, AND NUTS).

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

I CONSUME AT LEAST 3 CUPS OF FAT-FREE OR LOW-FAT DAIRY (MILK OR FORTIFIED SOYMILK) PRODUCTS PER DAY.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Member ID:________________________ First Name:______________________ Last Name__________________________

I LIMIT MY INTAKE OF FATS AND OILS HIGH IN SATURATED AND/OR TRANS FAT – OR I SUBSTITUTE WITH OILS LOW IN THESE FATS.
FYI: SATURATED FAT IS FOUND IN FOODS LIKE HIGH-FAT CHEESES, FATTY CUTS OF MEAT, CREAM, WHOLE MILK, BUTTER, AND ICE CREAM. TRANS FAT IS COMMONLY FOUND IN PROCESSED FOODS LIKE MARGARINE, SNACK FOODS, AND PACKAGED COOKIES AND CAKES.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

WHEN SELECTING AND PREPARING MEAT, POULTRY, DRY BEANS AND MILK PRODUCTS, I MAKE CHOICES THAT ARE LEAN, LOW-FAT OR FAT-FREE.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

I CHOOSE AND PREPARE FOODS WITH LITTLE ADDED SUGAR.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

I CHOOSE AND PREPARE FOODS WITH LITTLE SALT OR SALTY SEASONING.
FYI: COMMON SOURCES OF SODIUM INCLUDE RESTAURANT FOODS, BAKED GOODS, AND PROCESSED FOODS LIKE SOUP, FROZEN DINNER ENTREES, AND FAST FOOD. AND OF COURSE YOU'LL FIND IT IN THE SALT SHAKER, TOO.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

I CHOOSE WHOLE GRAIN BREADS, RICE AND PASTA OVER REFINED, PROCESSED OPTIONS.
FYI: WHOLE GRAINS KEEP THE ENTIRE KERNEL INTACT, WHILE REFINED GRAINS ARE MISSING PARTS OF THE KERNEL. THIS STRIPS THE GRAINS OF HEALTHY NUTRIENTS AND FIBER. EXAMPLES OF WHOLE GRAINS INCLUDE BROWN RICE, OATMEAL, AND WHOLE WHEAT BREAD AND PASTA.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

IN GENERAL, AT LEAST HALF THE GRAINS I CONSUME ARE FROM WHOLE GRAINS.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

AGE ≥ 50 - I INCLUDE FOODS WITH VITAMIN B12 IN MY DIET.

FYI: GOOD SOURCES OF VITAMIN B12 INCLUDE FISH AND SHELLFISH, LIVER, BEEF, EGGS, AND FORTIFIED CEREALS.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

IF CURRENTLY PREGNANT OR PLANNING TO BECOME PREGNANT - I AVOID EATING FISH WITH HIGH LEVELS OF MERCURY.

FYI: MERCURY CAN AFFECT BRAIN AND NERVOUS SYSTEM DEVELOPMENT IN UNBORN CHILDREN, SO IT'S IMPORTANT TO LIMIT YOUR INTAKE WHILE PREGNANT. MANY TYPES OF FISH CONTAIN MERCURY, SO CHECK BEFORE EATING. TYPES OF FISH WITH THE HIGHEST MERCURY LEVELS INCLUDE TUNA, MARLIN, TILEFISH, SWORDFISH, SHARK, AND MACKEREL. LOW-MERCURY TYPES OF FISH INCLUDE SALMON, FLOUNDER, HADDOCK, SOLE, TILAPIA, SCALLOPS, SHRIMP, AND CRAB.

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Lifestyle

Now we have some questions about your lifestyle habits.

DO YOU SMOKE OR USE TOBACCO PRODUCTS?

- ☐ Never
- ☐ No, I quit **more** than 5 years ago.
- ☐ No, I quit **less** than 5 years ago.
- ☐ Yes, I currently smoke or use tobacco products.
- ☐ Prefer not to answer

IF YOU HAVE EVER SMOKED OR USED TOBACCO PRODUCTS, PLEASE ANSWER ANY/ALL OF THE FOLLOWING 9 QUESTIONS THAT APPLY TO YOU.

SELECT THE TYPE OF TOBACCO PRODUCT(S): (CHOOSE ALL THAT APPLY.)

- ☐ Cigarettes
- ☐ Cigars
- ☐ Loose tobacco (pipe, hookah)
- ☐ Smokeless tobacco (dip, chew)

TOTAL YEARS SMOKING CIGARETTES:

- ☐ Less than 10 years
- ☐ 10 to 15 years
- ☐ 16 to 20 years
- ☐ Over 20 years

CIGARETTES PER DAY:

- ☐ Less than 1 pack
- ☐ About 1 pack
- ☐ Between 1 and 2 packs
- ☐ Two or more packs

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TOTAL YEARS SMOKING CIGARS:

- ☐ Less than 10 years
- ☐ 10 to 15 years
- ☐ 16 to 20 years
- ☐ Over 20 years

CIGARS PER DAY:

- ☐ 1 cigar (or less)
- ☐ cigars
- ☐ cigars
- ☐ More than 3 cigars

TOTAL YEARS SMOKING LOOSE TOBACCO:

- ☐ Less than 10 years
- ☐ 10 to 15 years
- ☐ 16 to 20 years
- ☐ Over 20 years

PIPES PER DAY:

- ☐ pipe (or less)
- ☐ pipes
- ☐ or more pipes

TOTAL YEARS USING SMOKELESS TOBACCO (DIP, CHEW):

- ☐ Less than 10 years
- ☐ 10 to 15 years
- ☐ 16 to 20 years
- ☐ Over 20 years

CANS PER WEEK:

- ☐ Less than 1 can
- ☐ About 1 can
- ☐ More than 1 can

WHICH STATEMENT BEST DESCRIBES YOUR ALCOHOL USE?

FYI: ONE DRINK = 1 GLASS OF WINE, 1 BEER, OR 1 AVERAGE MIXED DRINK

- ☐ I usually have more than 30 drinks per week.
- ☐ I usually have 15 to 30 drinks per week.
- ☐ I usually have 8 to 14 drinks per week.
- ☐ I usually have 1 to 7 drinks per week.
- ☐ I have a drink or two on rare or special occasions.
- ☐ I do not drink alcohol.
- ☐ Prefer not to answer

FEMALE – HOW OFTEN DO YOU HAVE 4 OR MORE DRINKS ON ONE OCCASION?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily
- ☐ Prefer not to answer

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Male – How often do you have 5 or more drinks on one occasion?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily
- ☐ Prefer not to answer

Are you currently taking prescription medication?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

If you are currently taking prescription medication, how often do you take your medication as prescribed by your doctor?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Prefer not to answer

Have you engaged in unprotected sex with more than one partner within the last 6 months?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

How would you rate your overall stress level?

- ☐ High
- ☐ Moderate
- ☐ Low
- ☐ Prefer not to answer

How many hours of sleep do you usually get each night?

________hours

How often do you buckle your seat belt when you drive or ride in a motor vehicle?

- ☐ Always (100% of the time)
- ☐ Usually (75% to 99% of the time)
- ☐ Sometimes (25% to 74% of the time)
- ☐ Rarely or never (less than 25% of the time)
- ☐ Does not apply

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

- ☐ Within 5 mph of the speed limit
- ☐ 6-10 mph over the speed limit
- ☐ 11-15 mph over the speed limit
- ☐ More than 15 mph over the speed limit
- ☐ Does not apply

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PLEASE INDICATE WHETHER THE FOLLOWING STATEMENTS APPLY TO YOU AND HAVE PERSISTED FOR AT LEAST 2 WEEKS:

I FEEL DOWN, DEPRESSED OR HOPELESS.

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

I FEEL LITTLE INTEREST OR PLEASURE IN DOING THINGS.

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

On the Job

ARE YOU CURRENTLY EMPLOYED (WORKING FOR PAY)?

- ☐ Yes
- ☐ No

THE NEXT QUESTIONS ARE ABOUT THE PAST SEVEN DAYS, NOT INCLUDING TODAY.

IF YOU WORK – DURING THE PAST SEVEN DAYS, HOW MANY HOURS DID YOU MISS FROM WORK BECAUSE OF YOUR HEALTH PROBLEMS?
FYI: INCLUDE HOURS YOU MISSED ON SICK DAYS, TIMES YOU WENT IN LATE, LEFT EARLY, ETC., BECAUSE OF YOUR HEALTH PROBLEMS. DO NOT INCLUDE TIME YOU MISSED TO PARTICIPATE IN THIS PROGRAM.
________ **HOURS**

IF YOU WORK – DURING THE PAST SEVEN DAYS, HOW MANY HOURS DID YOU MISS FROM WORK BECAUSE OF ANY OTHER REASON, SUCH AS VACATION, HOLIDAYS, TIME OFF TO PARTICIPATE IN THIS PROGRAM?
________ **HOURS**

IF YOU WORK – DURING THE PAST SEVEN DAYS, HOW MANY HOURS DID YOU ACTUALLY WORK?
________ **HOURS**

IF YOU WORK – DURING THE PAST SEVEN DAYS, DID HEALTH PROBLEMS AFFECT YOUR PRODUCTIVITY WHILE YOU WERE WORKING?
FYI: SCALE = 0-10. THINK ABOUT DAYS YOU WERE LIMITED IN THE AMOUNT OR KIND OF WORK YOU COULD DO, DAYS YOU ACCOMPLISHED LESS THAN YOU WOULD LIKE, OR DAYS YOU COULD NOT DO YOUR WORK AS CAREFULLY AS USUAL. IF HEALTH PROBLEMS AFFECTED YOUR WORK ONLY A LITTLE, CHOOSE A LOW NUMBER. CHOOSE A HIGH NUMBER IF HEALTH PROBLEMS AFFECTED YOUR WORK A GREAT DEAL.
CONSIDER ONLY HOW MUCH HEALTH PROBLEMS AFFECTED PRODUCTIVITY WHILE YOU WERE WORKING.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

[Health problems had no effect on my work] — [Health problems completely prevented me from working]

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DURING THE PAST SEVEN DAYS, HOW MUCH DID YOUR HEALTH PROBLEMS AFFECT YOUR ABILITY TO DO YOUR REGULAR DAILY ACTIVITIES, OTHER THAN WORK AT A JOB?

FYI: SCALE = 0-10. BY REGULAR ACTIVITIES, WE MEAN THE USUAL ACTIVITIES YOU DO, SUCH AS WORK AROUND THE HOUSE, SHOPPING, CHILDCARE, EXERCISING, STUDYING, ETC. THINK ABOUT TIMES YOU WERE LIMITED IN THE AMOUNT OR KIND OF ACTIVITIES YOU COULD DO AND TIMES YOU ACCOMPLISHED LESS THAN YOU WOULD LIKE. IF HEALTH PROBLEMS AFFECTED YOUR ACTIVITIES ONLY A LITTLE, CHOOSE A LOW NUMBER. CHOOSE A HIGH NUMBER IF HEALTH PROBLEMS AFFECTED YOUR ACTIVITIES A GREAT DEAL.

CONSIDER ONLY HOW MUCH HEALTH PROBLEMS AFFECTED YOUR ABILITY TO DO YOUR REGULAR DAILY ACTIVITIES, OTHER THAN WORK AT A JOB.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

[Health problems had no effect on my daily activities]

[Health problems completely prevented me from doing my daily activities]

Your Conditions

In the past 6 months, how many times have you been hospitalized or treated on an emergency basis (ER, urgent care) for each of the following conditions:

IF YOU HAVE ASTHMA, PLEASE ANSWER THE FOLLOWING 3 QUESTIONS:

IN THE PAST 6 MONTHS, HOW MANY TIMES HAVE YOU BEEN HOSPITALIZED OR TREATED ON AN EMERGENCY BASIS (ER, URGENT CARE) FOR ASTHMA?

Hospitalized

- ☐ 0 times
- ☐ 1-2 times
- ☐ 3+ times

Emergency treatment

- ☐ 0 times
- ☐ 1-2 times
- ☐ 3+ times

HOW OFTEN DO YOU TAKE YOUR ASTHMA MEDICATION AS PRESCRIBED?

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ I don't take medication

HOW CONFIDENT DO YOU FEEL THAT YOU CAN MANAGE YOUR ASTHMA SO THAT IT DOESN'T GET IN THE WAY OF THINGS YOU WANT TO DO?

- ☐ Extremely confident
- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ Not at all confident

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IF YOU HAVE COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE), PLEASE ANSWER THE FOLLOWING 3 QUESTIONS:

IN THE PAST 6 MONTHS, HOW MANY TIMES HAVE YOU BEEN HOSPITALIZED OR TREATED ON AN EMERGENCY BASIS (ER, URGENT CARE) FOR COPD?

Hospitalized

- ☐ 0 times
- ☐ 1-2 times
- ☐ 3+ times

Emergency treatment

- ☐ 0 times
- ☐ 1-2 times
- ☐ 3+ times

HOW OFTEN DO YOU TAKE YOUR COPD MEDICATION AS PRESCRIBED?

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ I don't take medication

HOW CONFIDENT DO YOU FEEL THAT YOU CAN MANAGE YOUR COPD SO THAT IT DOESN'T GET IN THE WAY OF THINGS YOU WANT TO DO?

- ☐ Extremely confident
- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ Not at all confident

IF YOU HAVE CAD (CORONARY ARTERY DISEASE), PLEASE ANSWER THE FOLLOWING 3 QUESTIONS:

IN THE PAST 6 MONTHS, HOW MANY TIMES HAVE YOU BEEN HOSPITALIZED OR TREATED ON AN EMERGENCY BASIS (ER, URGENT CARE) FOR CAD?

Hospitalized

- ☐ 0 times
- ☐ 1-2 times
- ☐ 3+ times

Emergency treatment

- ☐ 0 times
- ☐ 1-2 times
- ☐ 3+ times

HOW OFTEN DO YOU TAKE YOUR CAD MEDICATION AS PRESCRIBED?

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ I don't take medication

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How confident do you feel that you can manage your CAD so that it doesn't get in the way of things you want to do?

- ☐ Extremely confident
- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ Not at all confident

If you have CHF (congestive heart failure), please answer the following 3 questions:

In the past 6 months, how many times have you been hospitalized or treated on an emergency basis (ER, urgent care) for CHF?

Hospitalized

- ☐ 0 times
- ☐ 1-2 times
- ☐ 3+ times

Emergency treatment

- ☐ 0 times
- ☐ 1-2 times
- ☐ 3+ times

How often do you take your CHF medication as prescribed?

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ I don't take medication

How confident do you feel that you can manage your CHF so that it doesn't get in the way of things you want to do?

- ☐ Extremely confident
- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ Not at all confident

If you have diabetes, please answer the following 3 questions:

In the past 6 months, how many times have you been hospitalized or treated on an emergency basis (ER, urgent care) for your diabetes?

Hospitalized

- ☐ 0 times
- ☐ 1-2 times
- ☐ 3+ times

Emergency treatment

- ☐ 0 times
- ☐ 1-2 times
- ☐ 3+ times

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HOW OFTEN DO YOU TAKE YOUR DIABETES MEDICATION AS PRESCRIBED?

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ I don't take medication

HOW CONFIDENT DO YOU FEEL THAT YOU CAN MANAGE YOUR DIABETES SO THAT IT DOESN'T GET IN THE WAY OF THINGS YOU WANT TO DO?

- ☐ Extremely confident
- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ Not at all confident

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Health Goals

Within the next 6 months, are you planning to make any of the following changes?

IMPROVE YOUR EATING HABITS

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Does not apply

MANAGE YOUR WEIGHT

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Does not apply

GET MORE PHYSICAL ACTIVITY

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Does not apply

MANAGE YOUR STRESS LEVEL

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Does not apply

CUT BACK ON ALCOHOL

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Does not apply

QUIT TOBACCO

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Does not apply

Feedback

We want to hear from you! Please tell us about your experience.

THIS HEALTH ASSESSMENT WAS SIMPLE TO COMPLETE

- ☐ Strongly Agree
- ☐ Agree
- ☐ Not sure
- ☐ Disagree
- ☐ Strongly Disagree

THIS HEALTH ASSESSMENT WAS EASY TO UNDERSTAND

- ☐ Strongly Agree
- ☐ Agree
- ☐ Not sure
- ☐ Disagree
- ☐ Strongly Disagree

COMMENTS:

Member ID:________________________ First Name:______________________ Last Name__________________________