HEALTH RISK APPRAISAL

Your results will be kept strictly confidential as a component of your Protected Health Information

TODAY's DATE: ____

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1. Patient's Name:_______________________________________
2. Gender: ◯ Male ◯ Female
3. Date of Birth: ____
4. Are you pregnant? ◯ No ◯ Yes (Complete this form based on your health & lifestyle prior to becoming pregnant)
5. If diabetic, when was your last A1C test? ____________________

HEALTH RELATED BEHAVIORS

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6. How would you describe your cigarette smoking habits?
   - ◯ I still smoke, Go to question 7
   - ◯ I used to smoke, Go to question 8
   - ◯ I never smoked, Go to question 9
7. I still smoke _______ cigarettes per day, Go to question 9
8. a) How long has it been since you smoked cigarettes on a fairly regular basis? ________ years ________ months
   b) What is the average number of cigarettes you smoked per day in the two years before you quit?
   - ◯ Less than 9
   - ◯ 10-15
   - ◯ 16-19
   - ◯ 20+
9. What other forms of tobacco do you smoke or use?
   - ◯ Pipe
   - ◯ Cigars
   - ◯ Smokeless Tobacco
   - ◯ None
10. How often do you use drugs or medications (including prescription drugs) which effect your mood or help you to relax?
    - ◯ Almost every day
    - ◯ Sometimes
    - ◯ Rarely or never
11. How many drinks of alcoholic beverages do you have in a typical week?
    (one drink + one beer, one glass of wine, one shot of liquor, or one mixed drink) __________ Drinks
12. How many times in the last month did you drive or ride when the driver had perhaps had too much to drink? _________ Times last month
13. What percentage of the time do you usually buckle your safety belt when driving or riding?
    - ◯ 100%
    - ◯ 90-99%
    - ◯ 80-89%
    - ◯ Less than 80%
14. 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
    - ◯ More than 10 mph over the speed limit

15. Each day, how many servings of foods 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 cup vegetables, 1 medium fruit, ¾ cup cereal)
    - ◯ 5-6 servings/daily
    - ◯ 3-4 servings/daily
    - ◯ 1-2 servings/daily
    - ◯ Rarely/never
16. Each day, how many servings of food do you eat that are high in cholesterol or fat such as fatty meat, cheese, fried foods, or whole eggs? (serving size: 3.5 oz meat, 1 whole egg, 1 oz/slice cheese)
    - ◯ 5-6 servings/daily
    - ◯ 3-4 servings/daily
    - ◯ 1-2 servings/daily
    - ◯ Rarely/never
17. In the average week, how many times do you engage in physical activity (exercise or work which last at least 20 minutes without stopping and which is hard enough to make you breathe more heavily to make your heart beat faster)? Examples include running, brisk walking or heavy labor, e.g. chopping, lifting, digging, etc…
    - ◯ Less than one time per week
    - ◯ One or two times per week
    - ◯ 3 times per week
    - ◯ 4 or more times per week
18. How many hours of sleep do you usually get at night?
    - ◯ 6 hours or less
    - ◯ 7 hours
    - ◯ 8 hours
    - ◯ 9 hours or more

QUALITY OF LIFE INDICATORS

19. In general, how strong are your social ties with your family and/or friends?
    - ◯ Very strong
    - ◯ About Average
    - ◯ Weaker than average
    - ◯ Not sure
20. 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/misfortunes in the past year
    - ◯ Yes, one serious loss/misfortune in the past year
    - ◯ No
21. During the past year, how much effect has stress had on your health?
    - ◯ A lot
    - ◯ Some
    - ◯ Hardly any
    - ◯ None
22. Do you feel safe in your home?
    - ◯ Yes
    - ◯ No
23. Over the past two (2) weeks have you felt down, depressed or hopeless? ◯ Yes ◯ No
24. Over the past two (2) weeks have you felt little interest or pleasure in doing things? ◯ Yes ◯ No

25. Overall, how would you rate your health during the past 4 weeks?
    - ◯ Excellent
    - ◯ Very Good
    - ◯ Good
    - ◯ Fair
    - ◯ Poor
    - ◯ Very Poor
26. During the past 4 weeks how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?
    - ◯ Not at all
    - ◯ Very little
    - ◯ Somewhat
    - ◯ Quite a lot
    - ◯ Could not do physical activities
27. During the past 4 weeks, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?
    - ◯ Not at all
    - ◯ Very little
    - ◯ Somewhat
    - ◯ Quite a lot
    - ◯ Could not do physical activities
28. How much bodily pain have you had during the past 4 weeks?
    - ◯ None
    - ◯ Very mild
    - ◯ Moderage
    - ◯ Severe
    - ◯ Very Severe

    28a. What does your pain feel like?
    - ◯ Throbbing
    - ◯ Stabbing
    - ◯ Shooting
    - ◯ Dull
    - ◯ Sore
    - ◯ Sharp
    - ◯ Pinching
    - ◯ Cutting
    - ◯ Aching
    - ◯ Tingling

    28b. How does your pain change with time?
    - ◯ Continuous
    - ◯ Intermittent
    - ◯ Brief

    28c. How strong is your pain?
    - ◯ Mild
    - ◯ Discomforting
    - ◯ Distressing
    - ◯ Horrible
    - ◯ Excruciating

29. During the past 4 weeks, how much energy did you have?
   - ◯ Very much
   - ◯ Quite a lot
   - ◯ Some
   - ◯ A little
   - ◯ None
30. During the past 4 weeks, how much did your physical health or emotional problems limit your usual social activities with family and friends?
   - ◯ Not at all
   - ◯ A little bit
   - ◯ Some
   - ◯ Quite a lot
   - ◯ Could not do social activities
31. During the past 4 weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed, or irritable)?
   - ◯ Not at all
   - ◯ Slightly
   - ◯ Moderately
   - ◯ Quite a lot
   - ◯ Extremely
32. During the past 4 weeks, how much did personal or emotional problems keep you from doing your usual work, school, or other daily activities?
   - ◯ Not at all
   - ◯ Very little
   - ◯ Somewhat
   - ◯ Quite a lot
   - ◯ Could not do daily activities
33. In the past 12 months, how many times have you:

Visited a physician's office or clinic	◯ 0	◯ 1-2	◯ 3-5	◯ 6 or more
Gone to the emergency room	◯ 0	◯ 1-2	◯ 3-5	◯ 6 or more
Stayed overnight in a hospital	◯ 0	◯ 1-2	◯ 3-5	◯ 6 or more

34. When was the last time you visited a dentist? ___________________________________ (date)

35. When is the last time you had your vision checked? ___________________________________ (date)

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

Colon Cancer Screen:	◯ 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
Rectal Exam:	◯ 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
Tetanus Shot:	◯ 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

WOMEN ONLY

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

PAP Test:	◯ 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
Mammogram:	◯ 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
Breast Exam:(by	◯ Less than 1 year	◯ 1-2 years ago	◯ 2-3 years ago	◯ 3-4 years ago
physician or nurse)	◯ 5-6 years ago	◯ 7 or more years ago	◯ Never	◯ Don't know

38. Have you had a hysterectomy operation?

◯ Yes ◯ No

PERSONAL INFORMATION

39. Current Marital Status:
    - ◯ Single (never married)
    - ◯ Married
    - ◯ Separated
    - ◯ Widowed
    - ◯ Divorced
    - ◯ Other ____
40. Race/Ethnicity (Check all that apply):
    - ◯ Asian
    - ◯ Black/African American
    - ◯ Pacific Islander or Native Hawaiian
    - ◯ American Indian/Native Alaskan
    - ◯ Hispanic
    - ◯ White/Caucasian
    - ◯ Other
41. Highest level of education you have achieved:
    - ◯ Some high school or less
    - ◯ High school graduate
    - ◯ Some College
    - ◯ College graduate
    - ◯ Post graduate or professional degree

HEALTH PLANNING QUESTIONS:

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

Increase physical activity	◯ Yes	◯ No	◯ Don't know	◯ Not Needed
Lose Weight	◯ Yes	◯ No	◯ Don't know	◯ Not Needed
Reduce alcohol use	◯ Yes	◯ No	◯ Don't know	◯ Not Needed
Quite or cut down on smoking	◯ Yes	◯ No	◯ Don't know	◯ Not Needed
Reduce fat/cholesterol intake	◯ Yes	◯ No	◯ Don't know	◯ Not Needed
Lower blood pressure	◯ Yes	◯ No	◯ Don't know	◯ Not Needed
Lower cholesterol level	◯ Yes	◯ No	◯ Don't know	◯ Not Needed
Cope better with stress	◯ Yes	◯ No	◯ Don't know	◯ Not Needed