partnership HEALTH CENTER
WeCare TLC Integrity Health

Health Assessment Questionnaire

***WARNING*- Do not eat 8 hours prior to having your blood drawn. You should take normal medications and may drink plenty of water or decaffeinated coffee.(No sugar, artificial sweetener or cream)**

****Please print clearly. You may leave the question blank if you choose not to answer.**

First Name: Last Name:
Address 1:
Address 2:
City: State: Zip Code:
Social Security Number: Member ID:
Home Phone Number: Cell Phone:
Work Phone:
When is the best time to contact you? (Circle one) Morning Afternoon Evening
Email Address:
(By providing my email address, I am consenting to be contacted by email even though it is not secure method to communicate health information)
Date of Birth:
Who is your primary care doctor? First Name: Last Name:
Physician's Telephone Number:

Please circle or fill in the appropriate answers:

1. **How would you like to receive health information? (circle one)** Phone, Email, Regular Mail
2. **What is your sex?** Male Female
3. **What is your weight?** _____
4. **What is your height?** **(You can convert to inches or state it as 5'6. Always round to nearest inch)** _____
5. **Do you wear a seat belt when in a vehicle?** Yes No
6. **Do you feel safe in your home?** ***(Abuse Hotline 1-800-799-SAFE (7233))*** Yes No
7. **How do you perceive your own health? (circle one)** Excellent, Good, Average, Poor
8. **What was your most recent systolic blood pressure reading (Top number)?**
   <100
   100-110
   111-120
   121-130
   131-139
   140-150
   151-160

161-170
171-174
175 or >

9. What was your most recent diastolic blood pressure reading (bottom number)
<60
60-69
70-79
80-89
90-95
96-100
101 or >

9. Do you currently have high blood pressure? **(answer yes if taking blood pressure medication)** Yes No

10. Do you take medication for high blood pressure? Yes No

11. Has either of your parents had high blood pressure? Yes No
12. Have you had a heart attack? Yes No

13. Has either of your parents had a heart attack? Yes No

14. Do you exercise regularly? Yes No

15. How many days a week do you exercise? (circle one) 0, 1, 2, 3, 4, 5, 6, 7

16. How long is your exercise session? (circle one) I do not exercise, Less than 15 min, 15 to 30 min, 30 minutes or more

17. Circle all the exercises you participate in (circle one): I do not exercise, Walking, Running, Bicycling, Swimming, Aerobics, Jazzercise, Weights, Group Workouts, Other

18. Do you have chronic lower back pain? Yes No

19. Do you get chest pains? Yes No

20. Have you ever been told you have high cholesterol/lipids? Yes No

21. Do you ever get leg cramps or do your feet turn blue? Yes No

22. Do leg cramps ever wake you or keep you from daily activities/walking? Yes No

23. Have you ever had a stroke? Yes No

24. Has either of your parents had a stroke? Yes No

25. Do you now or have you ever used tobacco products? Yes No

26. How many cigarettes do you smoke some days or every day? Include smokeless tobacco products. (circle one) 1 to 5 per day, more than 6, Stopped less than 5 years ago, Stopped more than 5 years ago, Chew Tobacco

27. **Have you ever had a dental/oral exam if you chew tobacco?** Yes, No, N\A

28. **Do you have trouble breathing or get short of breath?** Yes No

29. **Do you have a family history of asthma?** Yes No

30. **Do you wake in the middle of the night unable to breathe?** Yes No

31. **Do you snore?** Yes No

32. **Have you ever been diagnosed with sleep apnea?** Yes No

33. **Does anyone else in your household smoke?** Yes No

34. **Do you have or have you ever had cancer?** Yes No

35. **Has anyone in your immediate family had cancer?** Yes No

36. **Have you ever had a colonoscopy or sigmoidoscopy if 50 years old or older? (circle one)** Yes, No, N\A

37. **Have you had a mammogram if 40 years old or older? (Circle one, females only)** Yes, No, N\A

38. **Have you ever had an abnormal mammogram? (Female only)** Yes No

39. **Have you ever had a breast biopsy? (Female only)** Yes No

40. **Do you have breast implants? (Female only)** Yes No

41. **Have you had a pap smear in the past 3 years? (Female only)** Yes No

42. **Are you taking hormones? (Female only)** Yes No

43. **Have you had a prostate exam and or a PSA test completed if 45 years old or older? (Circle one, males only)** Yes, No, N\A

44. **Do you have kidney or urination problems?** Yes No

45. **Do you have recurrent urinary tract or bladder infections?** Yes No

46. **Has either of your parents had kidney problems?** Yes No

47. **Have you ever been told you have high blood sugar or diabetes?** Yes No

48. **Has either of your parents had high blood sugar or diabetes?** Yes No

49. **Do you have problems with your weight?** Yes No

50. **Do you have stomach, heartburn or gas problems?** Yes No

51. Have you ever vomited blood? Yes No

52. Do you take anti-inflammatory drugs such as Ibuprofen, Advil, Motrin, or Aleve? Yes No

53. Have you ever been told that you have blood in your stool or black stool? Yes No

54. Have you ever been told you have liver disease or hepatitis? Yes No

55. If yes, what type of liver disease\hepatitis? (circle one) A, B C , Cirrhosis/fatty liver

56. Do you drink alcohol? (beer, wine, liquor) Yes No

57. How many alcoholic drinks do you have a day? (circle one)
1 - 2 per day, 3 - 5 per day, 6 or more per day,
6 or more per weekend, Social Drinker. I no longer drink

58. Did you stop drinking because you had a problem with alcohol? Yes No

59. Do you ever feel guilty for drinking alcohol? Yes No

60. Do you ever think about having you first alcohol drink in the morning? Yes No

61. Have you ever felt you should cut down on alcoholic drinks? Yes No

62. Do you have a history of depression or mental illness? Yes No

63. Has either of your parents had depression or mental illness? Yes No

64. Have you felt down or blue lately? Yes No

65. Have you felt any or all of the following? (circle any that apply)

Trouble sleeping, Loss of appetite, Difficulty concentrating, Tiredness

66. Have you ever felt like hurting yourself? ***(1-800-SUICIDE or 1800-784-2433)*** Yes No

67. Do you feel excessive stress? Yes No

68. What do you do to relieve stress? (circle one) read/exercise/have sex, eat/watch TV/sleep, drink alcohol, take medications

69. Are you in a sexual relationship with one person? (circle one)
Yes, No, I am not sexually active

70. Have you ever had more than one sexual partner? Yes No

71. Do you or your partner(s) wear a condom? Yes No

72. Have you been told you are HIV positive or have AIDS? Yes No

73. Have you ever been physically or emotionally abused? Yes No

(National Domestic Violence Hotline 1-800-799-SAFE (7233) or www.ndvh.org)

You must agree to the following terms in order to obtain the questionnaire results:

☐ **I understand my *Health Assessment* results are not a medical diagnosis. I will consult my physician for interpretation and further intervention.**

☐ **I understand that to obtain a health assessment, I must provide a blood sample for the purpose of laboratory tests. I further understand that the sample will be sent to the lab center for processing and the results reported to a MedWatch Total Lifestyle Counselor and\or our medical staff, who may contact me to discuss my results and to help me establish my health goals. I consent to be part of the Total Lifestyle Counseling program. No individual lab results or other health information will be shared with my employer. A copy of my lab results will be returned to me directly, and I UNDERSTAND IT IS MY RESPONSIBILITY TO TAKE THEM TO MY DESIGNATED PRIMARY CARE GIVER FOR FURTHER CARE, INTERVENTION AND INTERPRETATION.**

Optional:

☐ **I also authorize release of lab results and other health information to the doctor I have identified on page one (1) of this document.**

Dr. Name: _____ Fax Number: _____

☐ **Not Authorized**

Signature: _____

Today's Date: _____

Language Preference: _____

For Staff Use Only

Fasted for 8 hours Yes No Blood Pressure /