Fax this form to: 502-489-6440

Health Assessment

Name:___________________________________ Date:_______________________________

Date of Birth:____________________________ Employer:___________________________

Insured's Name:__________________________ E-mail Address:_______________________

1. **What is your gender?**
   - **a.** ☐ Male
   - **b.** ☐ Female
2. **How would you describe your ethnic origin?**
   - **a.** ☐ Asian
   - **b.** ☐ Black or African-American
   - **c.** ☐ Hispanic or Latino
   - **d.** ☐ Indian
   - **e.** ☐ Native American, Eskimo or Inuit
   - **f.** ☐ Native Hawaiian or other Pacific Islander
   - **g.** ☐ White/Caucasian
   - **h.** ☐ Multi-ethnic
   - **i.** ☐ Other
   - **j.** ☐ Unknown
3. **What is the highest level of education you have completed**?
   - **a.** ☐ Grade School or less
   - **b.** ☐ Some High School
   - **c.** ☐ High School Graduate
   - **d.** ☐ Some College or Vocational School
   - **e.** ☐ College Graduate
   - **f.** ☐ Post-graduate or Professional School
4. **What type of job do you perform?**
   - **a.** ☐ Manual
   - **b.** ☐ Clerical/Administrative
   - **c.** ☐ Middle management/Technical

d. Senior management/Professional

5. **What is your BMI?** (See the BMI Calculator on the main page if you are completing this electronically, or see the attached sheet on the back if you are completing by mail)
   - **a.** BMI less than 24
   - **b.** BMI less than 30
   - **c.** BMI less than 40
   - **d.** BMI greater than 40
6. **What is your waist measurement?**
   - **a.** less than 40 inches Male
   - **b.** less than 35 inches Female
   - **c.** greater than 35 for females or greater than 40 for males
7. **What is your resting pulse rate?**
   - **a.** Below 60
   - **b.** 60-99
   - **c.** 100-119
   - **d.** 120 and above
8. **What have you been told about your blood pressure**?
   - **a.** My blood pressure has been high (over 140/90)
   - **b.** My blood pressure has been moderately high (between 120/80 and 140/90)
   - **c.** My blood pressure is normal (below 120/80)
   - **d.** I don't know
9. **What was your most recent blood sugar (glucose) reading?**
   - **a.** less than 60
   - **b.** 60 – 99
   - **c.** 100 – 120
   - **d.** greater than 120
10. **What is the most recent HgbA1c reading**?
   - **a.** 4 or below
   - **b.** 5 – 6
   - **c.** 7 – 8
   - **d.** 9 and above
   - **e.** Does Not Apply

11. What was your most recent cholesterol reading?

- **a.** □ 170's or less
- **b.** □ 180's – 190's
- **c.** □ 200 – 230's
- **d.** □ greater than 240
- **e.** □ Unknown

12. What was your most recent LDL reading?

- **a.** □ 110's or less
- **b.** □ 120's – 150's
- **c.** □ 160's – 180's
- **d.** □ greater than 190
- **e.** □ Unknown

13. What was your most recent HDL reading?

- **a.** □ 60's or above
- **b.** □ 50's
- **c.** □ 40's
- **d.** □ less than 40
- **e.** □ Unknown

14. What was your most recent triglyceride level?

- **a.** □ less than 150
- **b.** □ 150 – 199
- **c.** □ greater than 200
- **d.** □ Unknown

15. Have you had any major illnesses in the past five years? □ No □ Yes

If yes, please specify:____

16. Do you have any disabilities? □ No □ Yes

If yes, please specify:____

17. Woman's health. □ Not Applicable

A. **Procedures within the last 5 years:**

- **a.** Breast exam (By a practitioner) □ No □ Yes Date: ________________________
- **b.** Pap smear □ No □ Yes Date: ____
- **c.** Mammogram □ No □ Yes Date: ____

B. **Are you currently pregnant**? □ No □ Yes Due Date: __________________________

C. **Do you perform a monthly breast self-exam**? □ No □ Yes

If no, have you been instructed on how to perform a breast self-exam? □ No □ Yes

D. **How many full term pregnancies have you had**?

a. □ 0

b. □ 1-2

c. □ 3-4

d. □ 5 or more

E. **What age were you when you became pregnant for the first time**?

a. □ less than 18

b. □ 19-25

c. □ 26-35

d. □ greater than 35

F. **Have you given birth to a child who weighed 9 lbs or more**? □ No □ Yes

G. **Have you ever suffered from breast cancer or had a mastectomy**? □ No □ Yes

H. **Have you ever had benign breast disease (lump in the breast)?** □ No □ Yes

I. **Which of the following applies to you**?

a. □ Still menstruating

b. □ Periods stopped under the age of 45

c. □ Periods stopped over the age of 45

d. □ Hysterectomy

e. □ None of the above

J. **Do you have pain or difficulty passing urine?** □ No □ Yes □ Sometimes

K. **Do you need to pass urine more frequently than you used to**? □ No □ Yes

18. Men's Health. □ Not Applicable

A. Procedures within the last 5 years:

a. Testicular Exam (By a practitioner) □ No □ Yes Date: ______________________

b. Prostate Exam □ No □ Yes Date: ____

c. PSA Test □ No □ Yes Date: ____

B. **Do you perform a monthly testicular self-exam**? □ No □ Yes

If no, have you been instructed on how to perform a testicular self-exam? □ No □ Yes

C. **Do you perform a monthly breast self-exam**? □ No □ Yes

If no, have you been instructed on how to perform a breast self-exam? □ No □ Yes

D. **Have you ever suffered from breast cancer or had a mastectomy**? □ No □ Yes

E. **Have you ever had benign breast disease (lump in the breast)?** □ No □ Yes

F. **Do you have pain or difficulty when passing urine**? □ No □ Yes □ Sometimes

G. **Do you need to pass urine more frequently than you used to**? □ No □ Yes

19. Please indicate in the box's below whether you are currently being treated or have been treated in the past for the following items:

	PAST TREATMENT	CURRENT TREATMENT
a. Allergies	☐ No ☐ Yes	☐ No ☐ Yes
b. Anemia	☐ No ☐ Yes	☐ No ☐ Yes
c. Angina	☐ No ☐ Yes	☐ No ☐ Yes
d. Arthritis	☐ No ☐ Yes	☐ No ☐ Yes
e. Asthma	☐ No ☐ Yes	☐ No ☐ Yes
f. Breast cancer	☐ No ☐ Yes	☐ No ☐ Yes
g. Blood Clots	☐ No ☐ Yes	☐ No ☐ Yes
h. Cervical cancer	☐ No ☐ Yes	☐ No ☐ Yes
i. Colon cancer	☐ No ☐ Yes	☐ No ☐ Yes
j. Lung cancer	☐ No ☐ Yes	☐ No ☐ Yes
k. Other cancer	☐ No ☐ Yes	☐ No ☐ Yes
l. Chronic back pain	☐ No ☐ Yes	☐ No ☐ Yes
m. Chronic neck pain	☐ No ☐ Yes	☐ No ☐ Yes
n. Colon polyps	☐ No ☐ Yes	☐ No ☐ Yes
o. CHF	☐ No ☐ Yes	☐ No ☐ Yes
p. COPD	☐ No ☐ Yes	☐ No ☐ Yes
q. Depression	☐ No ☐ Yes	☐ No ☐ Yes
r. Diabetes type 1	☐ No ☐ Yes	☐ No ☐ Yes
s. Diabetes type 2	☐ No ☐ Yes	☐ No ☐ Yes
t. Emphysema	☐ No ☐ Yes	☐ No ☐ Yes
u. Gestational Diabetes	☐ No ☐ Yes	☐ No ☐ Yes
v. GERD	☐ No ☐ Yes	☐ No ☐ Yes
w. Heart attack	☐ No ☐ Yes	☐ No ☐ Yes
x. Hypertension	☐ No ☐ Yes	☐ No ☐ Yes
y. Irregular heart beat	☐ No ☐ Yes	☐ No ☐ Yes
z. Heart disease	☐ No ☐ Yes	☐ No ☐ Yes
aa. Chest Pain	☐ No ☐ Yes	☐ No ☐ Yes
bb. Migraines	☐ No ☐ Yes	☐ No ☐ Yes
cc. Osteoporosis	☐ No ☐ Yes	☐ No ☐ Yes
dd. Stroke	☐ No ☐ Yes	☐ No ☐ Yes

20. Have you had the following health tests or procedures within the last 5 years?

If so, please give the date you last had the procedure performed.

a. Colonoscopy ☐ No ☐ Yes Date: ___________________________

b. Digital rectal exam ☐ No ☐ Yes Date: ______________________

c. Flu vaccine ☐ No ☐ Yes Date: ____________________________

d. Glaucoma screening ☐ No ☐ Yes Date: _____________________

e. Physical exam ☐ No ☐ Yes Date: __________________________

f. Stool blood test ☐ No ☐ Yes Date: _________________________

g. Vision exam ☐ No ☐ Yes Date: ____________________________

h. Dental exam ☐ No ☐ Yes Date: ____________________________

21. Has a biological parent, brother, or sister had any of the following?

a. Alcoholism ☐ No ☐ Yes

b. Asthma ☐ No ☐ Yes

c. Bleeding or clotting disorder ☐ No ☐ Yes

d. Breast cancer ☐ No ☐ Yes

e. Colon cancer ☐ No ☐ Yes

f. Any other type of Cancer ☐ No ☐ Yes

g. Colon polyps ☐ No ☐ Yes

h. Depression ☐ No ☐ Yes

i. Diabetes ☐ No ☐ Yes

j. Heart attack ☐ No ☐ Yes

k. Angina or heart disease before age 55 ☐ No ☐ Yes

l. High blood pressure ☐ No ☐ Yes

m. High Cholesterol ☐ No ☐ Yes

n. Stroke ☐ No ☐ Yes

o. Substance Abuse ☐ No ☐ Yes

22. Which of the following applies to your natural mother?

a. ☐ Alive and aged 65 or less

b. ☐ Died of a heart attack or heart disease aged 65 or less

c. ☐ Alive aged over 65,

d. ☐ Died of a heart attack or heart disease aged over 65

e. ☐ Don’t know

23. Which of the following applies to your natural father?

a. ☐ Alive and aged 65 or less

b. ☐ Died of a heart attack or heart disease aged 65 or less

c. ☐ Alive and aged over 65,

d. ☐ Died of a heart attack or heart disease aged over 65

e. ☐ Don't know

24. Do you smoke? ☐ No ☐ Yes

25. How many (cigarettes, cigars or bowls) per day?_________________________________

a. "Cigarettes" ☐ No ☐ Yes How many years have you smoked?__________

b. "Cigars" ☐ No ☐ Yes How many years have you smoked?__________

c. "Pipe" ☐ No ☐ Yes How many years have you smoked?__________

26. Do you use Chewing or smokeless tobacco? ☐ No ☐ Yes

If yes, how many pouches or cans do you use per day? ___________________

27. Are you exposed to secondhand smoke on a daily basis? ☐ No ☐ Yes

28. How many days per week do you consume alcoholic drinks?

a. ☐ 0

b. ☐ 1-2

c. ☐ 3-4

d. ☐ 5 or more

29. On an average day, how many alcoholic drinks do you usually consume?

a. ☐ 0

b. ☐ 1-2

c. ☐ 3-4

d. ☐ 5 or more

30. What alcoholic beverage do you normally drink?

a. ☐ Beer

b. ☐ Wine

c. ☐ Other____________________________

31. Have you had 5 or more alcoholic drinks in a single sitting in the last 6 months? ☐ No ☐ Yes

32. How many times in the last 6 months did you drive when you had too much to drink?

a. ☐ 0

b. ☐ 1

c. ☐ 3

d. ☐ 3 or more

33. How many times in the last 6 months did you ride with someone who had too much alcohol to drink?

a. ☐ 0

b. ☐ 1

c. □ 2
d. □ 3 or more

34. On average, how many servings of the following foods do you eat per day?

a. Fruits or vegetables (1 serving = 1 cup)
  i. □ 0
  ii. □ 1-2
  iii. □ 3-4
  iv. □ 5 or more

b. Whole-grain foods (1 serving = 1 slice of bread, 1 cup of cereal or ½ cup rice or pasta)
  i. □ 0
  ii. □ 1
  iii. □ 2
  iv. □ 3 or more

c. Low fat dairy products (1 serving = 1 cup)
  i. □ 0
  ii. □ 1
  iii. □ 2
  iv. □ 3 or more

d. High quality proteins (1 serving = 1 ounce)
  i. □ 0
  ii. □ 1
  iii. □ 2
  iv. □ 3 or more

e. High fat foods (1 serving = 1 teaspoon)
  i. □ 0
  ii. □ 1
  iii. □ 2
  iv. □ 3 or more

35. How many times per week do you exercise?

a. □ 0
b. □ 1-2
c. □ 3-4
d. □ 5 or more

36. How many times per week do you perform cardiovascular exercises?

a. □ 0

b. 1-2

c. 3-4

d. 5 or more

37. How many times per week do you perform strength building exercises?

a. 0

b. 1-2

c. 3-4

d. 5 or more

38. How often do you buckle your seat belt when riding in a motor vehicle?

a. Never

b. Sometimes

c. Most of the time

d. Always

39. In the past year have you felt a persistent numbness, tingling or burning in your:

a. Hands

b. Fingers

c. Feet

d. Toes

40. If you are sexually active and not in a committed relationship with one partner, do you always use protection, such as a condom, during sexual activity? No Yes

41. Over the past 2 weeks,

a. have you felt down, depressed, or hopeless? No Yes

b. have you felt little interest or pleasure in doing things? No Yes

42. Do you ever use prescription medications to relax or change your mood? No Yes

43. Do you use stress reducing techniques such as exercise, meditation, prayer, journaling or any other technique? No Yes

44. In the past year, have you experienced:

a. Feelings of hopelessness or guilt? No Yes

b. Loss of appetite, weight gain/loss of 20 lbs or more? No Yes

c. Decreased energy/fatigue? No Yes

d. Persistent sadness? No Yes

e. Insomnia/oversleeping? No Yes

f. Difficulty concentrating/making decisions? No Yes

g. Persistent or troublesome anxiety? No Yes

h. Problems with a friend, co-worker or supervisor? No Yes

i. Death of a loved one? □ No □ Yes

j. Depression? □ No □ Yes

k. Divorce/separation? □ No □ Yes

l. Financial difficulty? □ No □ Yes

m. Job loss/fear of job loss? □ No □ Yes

n. Job stress? □ No □ Yes

o. Moving/relocation? □ No □ Yes

p. Violence? □ No □ Yes

q. Problems with your health? □ No □ Yes

45. Over the last year, how would you describe your health compared to others your age?

a. □ Excellent

b. □ Very Good

c. □ Good

d. □ Fair

e. □ Poor

46. In the past year, how many times have you been to the doctor?

a. □ 0

b. □ 1-3

c. □ 4-6

d. □ 7 or more

47. In the past year, how many times have you been hospitalized overnight?

a. □ 0

b. □ 1-3

c. □ 4-6

d. □ 7 or more

48. In the past year, how many times have you been to the Emergency Room?

a. □ 0

b. □ 1

c. □ 2

d. □ 3 or more

49. In the past year, how many times have you missed work due to an illness or injury?

a. □ 0

b. □ 1-2

c. □ 3-4

d. □ 5 or more

50. How many prescriptions do you take on a regular basis?

- **a.** □ 0
- **b.** □ 1-3
- **c.** □ 4-6
- **d.** □ 7 or more

51. In the past year, how many times have you been to the dentist?

- **a.** □ 0
- **b.** □ 1
- **c.** □ 2
- **d.** □ 3 or more