WELLNESS COUNCIL OF WV

Health Risk Appraisal

Last Name: ________________________ First Name: ____________________

Street Address: ____

City/State/Zip Code: ____

E-mail address: ____

Today's Date: _______________________ SSN: _________________________

Telephone: (work) _______________________ (home) _________________________

Age: ___________ Sex: Male Female

Height: _____ft_____inches Weight: ___________ pounds

Ethnic Origin:
- African American
- American Indian
- Asian
- Caucasian
- Hispanic
- Muilti-ethnic
- Pacific Islander
- Other

Education: (highest level completed)
- ___ No high school diploma
- ___ High School diploma
- ___ College degree
- ___ Masters Degree or more

What was your most recent blood pressure? __________/___________mmHg
If you aren't sure, circle the most accurate range:
- High (160/95 or more)
- Moderate-high (140/90-159/94)
- Average (121/81-139/89)
- Low-normal (120/80 or lower)
- Don't know

What was your most recent cholesterol level? _________ mg/dl
If you aren't sure, circle the most accurate range:
- High (240 or more)
- Moderate-high (200-239)
- Average (181-199)
- Low-normal (180 or less)
- Don't know

Do you currently take any of the following medications? (circle all that apply)
- Antidepressants
- blood pressure medicine
- Blood thinners
- diabetes medicine (including insulin)
- Heart medicine
- High cholesterol medicine

Has your doctor ever told you that you have had any of the following? (circle all that apply)
- Allergies
- Angina or chest pain
- Arthritis or rheumatism
- Asthma
- Cancer
- Diabetes (type I)
- Diabetes (type II)
- Heart attach or myocardial infarction
- Kidney disease
- Hypertension or high blood pressure
- Lupus
- Migraines
- Sciatica or pinched back nerve
- Stroke

If you circled any of the above diagnoses—please indicate below any that you ARE NOT receiving treatment for currently:____
____

Do you currently have any of the following? (circle all that apply)

Achiness or soreness in the joints	any sore that does not heal
Change in bowel or bladder habits	chest pain
Chronic back pain	frequent allergy symptoms
Frequent/severe headaches	indigestion or difficulty swallowing
Obvious change in wart or mole	persistent cough or hoarseness
Restricted physical activity	shortness of breath
Ulcer or gastrointestinal bleeding	Unexplained dizziness
Thickening or lump in breast/elsewhere	
Severe stress	

Has a natural parent, brother, sister or child had any of the following: (circle all that apply)

Cancer	Diabetes
Heart attack before age 55	Hypertension/high blood pressure
Kidney disease	Stroke

When were your most recent health exams/tests?

Physical Exam	1 year	2 years	>2 years	never
Blood Pressure	1 year	2 years	>2 years	never
Vision	1 year	2 years	>2 years	never
Digital rectal exam	1 year	2 years	>2 years	never
Stool blood test	1 year	2 years	>2 years	never
Cholesterol exam	1 year	2 years	>2 years	never
Glaucoma screen	1 year	2 years	>2 years	never
Dental check-up	6 mos.	1 year	>1 year	never

Women Only:

Pap test	1 year	2 years	>2 years	never
Mammogram	1 year	2 years	>2 years	never
Breast Exam	1 year	2 years	>2 years	never

How would you describe your physical health?

Excellent Good Fair Poor

How strongly do you agree with the following? (1-Strongly disagree, 5- Strongly Agree)

My health is excellent.	1	2	3	4	5
I am as healthy as anyone I know.	1	2	3	4	5
I expect my health to get worse.	1	2	3	4	5
I seem to get sick easier than others.	1	2	3	4	5

Men Only:

Do you do a monthly testicular self exam? Yes No

Women Only:

How many women in your natural family (mother, sisters, grandmothers or aunts) have had breast cancer?

None 1-2 3 or more Not sure

Do you do a monthly breast self-exam? Yes No

Men and Women:

Are you or your spouse pregnant? Yes No

Are you or your spouse planning to become pregnant in the next year?

Yes No

If you answered yes to either of these questions, are you or your spouse under a doctor or a midwife's supervision? Yes No

Physical Activity:

In the past year, how many days per week did you participate in: (average)

Aerobic Exercise 1-2 3-4 5 or more days per week

Strength Building exercise 1-2 3-4 5 or more days per week

Nutrition/Eating Habits:

How many servings or fruits and/or vegetables do you eat per day?

1-2 3-4 5 or most days

How many servings of high fiber food do you eat every day? (whole grains, fresh fruits/vegetables)

1-2 3-4 5 or most days

On average, how many servings of high fat food do you eat per day?

1-2 3-4 5 or most days

Personal Habits:

Which of the following best describes your tobacco use?

___ I have never used tobacco
___I am a former tobacco user
___I am a current tobacco user

If you checked the last answer, on an average day how much tobacco do you use? ______________________________

(i.e.: ½ pack cigarettes daily, 3 cigars daily, 1 can of snuff/day)

If you are a tobacco user, how do you feel about quitting?

___ I am currently trying to quit.
___ I would like to quit but feel I would not succeed.
___ I would like to quit and am confident I will succeed.
___I am ready to quit and want more information.
___I am not ready to quit.

In an average week, how many alcoholic drinks do you consume?

0 1-2 3-5 5 or more

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

How many times in the last year have you driven a motor vehicle after consuming more than 1 alcoholic drink? Once twice three times or more

Do you always use your seatbelt when driving or riding in a motor vehicle? Yes No

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

Within 5 mph 6-10 mph 11mph or more over the speed limit

How frequently do you operate a motor vehicle while talking on a cell phone, text messaging or checking e-mail? Never Seldom Often Frequently

When lifting objects, even when they are not heavy, do you use proper lift techniques?

Yes No

How often do you do activities with your hands that involve repeated gripping or pinching movement? (type on a keyboard, use a wrench or hand tool, write with a pen/pencil)

Never Seldom Often Frequently

Do you have significant contact with any of the following? (circle all that you do have significant contact with…)

- Noxious fumes/toxins/hazardous chemicals
- Radiation
- Blood or blood products
- Excessive noise levels
- Second hand smoke
- Excessive lifting or loads too heavy
- Poorly designed/poorly lit work station
- Long periods of sitting or standing

Personal Relationships:

In the past year, have you had a serious problem with: (circle all that apply?)

Friend/co-worker	death of a loved one
Depression	divorce/separation
Finances	job loss
Job stress	lost work time/disability
Stress `	violence
Your family	your health
Your relationships	your job
Your supervisor	moving/relocation

How often do you use stress reducing techniques? (i.e. exercise, meditation, prayer, journaling, etc.0 Never Seldom Often Frequently

How strongly do you agree with the following statements? (1-strongly disagree, 5- strongly agree)

In general, I am satisfied with my job.	1	2	3	4	5
In general, I am satisfied with my life.	1	2	3	4	5
In the past year, stress has affected my health.	1	2	3	4	5
I would like to improve my health.	1	2	3	4	5
I would like to lose weight.	1	2	3	4	5
I would like to increase my physical activity.	1	2	3	4	5
I would like to improve my eating habits.	1	2	3	4	5
I would like to better manage my stress.	1	2	3	4	5

What is the best way for you to receive health information? (Mark up to three.)

Audio tapes	internet based information	support group
Community program	personal counseling	video materials
Computer software	printed materials	worksite based programs
Faxed information	newsletter	“Help” line (telephone)
Self-care books/manual		

In the past year, how many times have you personally seen a physician?

1-2 3-4 5 or more

In the past year, how many times have you personally been hospitalized?

1-2 3-4 5 or more

In the past year, how many times have you missed work due to illness?

1-2 3-4 5 or more

Do you have a medical condition that will require the use of a healthcare provider in the next year? Yes No

Do you have a personal physician? Yes No

Do you understand your healthcare benefits? No Somewhat Yes

Are you comfortable talking to your physician about health issues? Yes No

Are you comfortable selecting your own family physician? Yes No

Are you comfortable treating minor illnesses or injuries? Yes No