Sample A. Sample
5555 Main Street, Apt. 4
Anytown, USA 00000-0000

☐ If your name or address is not correct, please check this box and then print your correct information below.

First Name

Last Name

Street Address

City

State ZIP

ACTIVEHEALTH MANAGEMENT®

5-Minute HEALTH ASSESSMENT

Please take a few minutes to answer these basic health questions as best you can. Your answers **will be kept private** and will help us give you the best information about your health. When you're done, just put it in the pre-paid envelope and drop it in the mail. Thank you.

GENERAL INFORMATION

1. Date of Birth ☐☐ month ☐☐ day ☐☐☐☐ year *example: 12 month 05 day 1990 year*

2. What is your height? ☐ feet ☐☐ inches *example: 5 feet 07 inches*

3. What is your weight in pounds? ☐☐☐ pounds *example: 175 pounds*

4. Your sex: ☐ Male — please skip to question 8 on page 2.
☐ Female — please continue below.

FOR WOMEN ONLY

5. If you are between the ages of 18 and 50, please check off which of these describes you.
☐ I am pregnant ☐ I plan to get pregnant soon ☐ I am breastfeeding
☐ I am not able to get pregnant ☐ I am not pregnant

6. When was your last Pap smear? (screening for cervical cancer)
☐ In the last year ☐ 1–3 years ago ☐ More than 3 years ago
☐ I don't remember ☐ Never ☐ I was told I don't need this exam

7. When was your last mammogram? (screening for breast cancer)
☐ In the last year ☐ 1–2 years ago ☐ More than 2 years ago
☐ I don't remember ☐ Never ☐ I was told I don't need this exam

Please skip to question 10.

FOR MEN ONLY

8. Have you discussed the risks and benefits of prostate cancer screening with your doctor? (Usually done for men 50 years of age and older)
☐ Yes ☐ No ☐ I don't remember

9. Have you had any of these tests to screen for prostate cancer? You can check more than one.
☐ Prostate exam ☐ PSA level ☐ Prostrate ultrasound
☐ Prostate biopsy ☐ None of these

YOUR GENERAL HEALTH

10. How would you describe your health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

11. How would you describe your stress level? ☐ High ☐ Medium ☐ Low or none at all

12. Have you felt little interest or pleasure in doing things in the past two weeks? ☐ Yes ☐ No

13. Have you felt down, depressed or hopeless in the past two weeks? ☐ Yes ☐ No

14. If you answered "Yes" to question 12 or 13:
Have you discussed these feelings with your doctor? ☐ Yes ☐ No

15. How many days did you miss work due to a long-term illness during the last 12 months?
☐ 5 or less ☐ More than 5 ☐ Not applicable

16. Did you miss any days from work in the last 12 months because you were taking care of a family member who was sick? If so, how many days?
☐ 5 or less ☐ More than 5 ☐ Not applicable

YOUR HEALTH HABITS

17. Do you smoke or chew tobacco? ☐ I smoke ☐ I chew tobacco ☐ I don't use tobacco

18. If you do use tobacco, would you like to cut down or quit? ☐ Yes ☐ No ☐ I'm currently in a program

19. If you drink alcohol, on average, how many drinks do you have in a day?
☐ 0–1 ☐ 2–3 ☐ 4–5 ☐ 6 or more

20. If you have three or more drinks a day, are you interested in cutting down or quitting?
☐ Yes ☐ No ☐ I'm currently in a program

21. How often do you exercise for 30 minutes or more? (walk, run, dance, ride a bike, etc.)
☐ Less than once a week ☐ 1–2 days a week ☐ 3–4 days a week ☐ 5 or more days a week
☐ I was told not to exercise by my doctor

22. Sleep can affect your health. On average, how many hours do you sleep?
☐ Less than 6 ☐ 6 or more

YOUR ALLERGIES

23. Are you allergic to any of the following? You can check more than one.

☐ Peanuts ☐ Other nuts ☐ Eggs ☐ Wheat ☐ Soy ☐ Milk ☐ Fish or shellfish
☐ Penicillin ☐ Sulfa drugs ☐ Aspirin ☐ Codeine ☐ Latex ☐ Iodine

24. Do you follow any of these diets? You can check more than one.

☐ Diabetic diet ☐ Low cholesterol diet ☐ Low salt diet

YOUR HEALTH CONDITIONS

25. Do you have any of these health conditions? You can check more than one.

- ☐ Acid Reflux (GERD)
- ☐ Arthritis (rheumatoid)
- ☐ Arthritis (osteoarthritis: wear and tear of joints)
- ☐ Asthma
- ☐ Blood Clots (e.g. in your legs or lungs)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (chronic bronchitis, emphysema)
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease (blocked vessel or heart attack)
- ☐ Heart Failure
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease (not on dialysis)
- ☐ Kidney Disease (on dialysis)
- ☐ Leukemia
- ☐ Low Back Pain (six weeks or longer)
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peripheral Artery Disease
- ☐ Prostate Cancer
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis
- ☐ Other conditions:

_____

_____

_____

YOUR MEDICATIONS

26. What type of medications do you take on a regular basis? You can check more than one.

☐ None ☐ Prescription medications ☐ Over-the-counter medications (do not need a prescription)

If you do not take any medications regularly, skip to YOUR DOCTOR VISITS on page 4.

27. Do you take more than six medications a day (prescription or over-the-counter)?

☐ Yes ☐ No

28. Do you take an aspirin every day or every other day?

☐ Yes ☐ No ☐ I was told not to take aspirin by my doctor

29. Do you always take all your medications like your doctor tells you to?

- ☐ Yes
- ☐ No, my medications are not helping me
- ☐ No, my medications are too expensive
- ☐ No, my medications are giving me side effects
- ☐ No, I forget to take my medications
- ☐ No, I am not taking prescription medications

YOUR DOCTOR VISITS

30. When was the last time you had the flu vaccine (e.g. flu shot or nasal spray)?
- ☐ In the last year
- ☐ More than a year ago
- ☐ I don't get the flu vaccine
- ☐ I am allergic to it
- ☐ I don't remember

31. Adults should get a tetanus shot every 10 years. Have you had one in the last 10 years?
- ☐ Yes
- ☐ No
- ☐ No, I am allergic
- ☐ I don't remember

32. When was the last time you went to a dentist?
- ☐ In the last 6 months
- ☐ 6–12 months ago
- ☐ More than 12 months ago
- ☐ I don't remember

33. When was your last eye exam by an eye doctor?
- ☐ In the last 12 months
- ☐ 1–2 years ago
- ☐ 3–4 years ago
- ☐ More than 4 years ago
- ☐ Never

34. When was the last time you were screened for colon cancer? *(Usually done for people 50 years of age or older)*
- ☐ I had a stool blood test in the last year
- ☐ I had a sigmoidoscopy or barium enema in the last 5 years
- ☐ I had a colonoscopy in the last 10 years
- ☐ None of the above
- ☐ I don't remember

YOUR TEST RESULTS

35. What is your most recent blood pressure? (within last 3 months)

☐☐☐ systolic (high number) ☐☐ diastolic (low number) example: *120 systolic 80 diastolic*

36. When was the last time you had a blood test to check your cholesterol?
- ☐ In the last year
- ☐ More than 1 year ago but within 5 years
- ☐ More than 5 years ago
- ☐ I don't know

37. If you had your cholesterol checked, what were the results?

☐☐☐☐ Total cholesterol ☐☐☐☐ LDL

☐☐☐☐ Triglycerides ☐☐☐ HDL

- ☐ I don't have or remember any of the cholesterol results

Thank you! SIMPLY RETURN IN THE ENVELOPE PROVIDED!

Want to learn more ways to improve your health?
Go to www.activehealthphr.net/phr

ACTIVEHEALTH MANAGEMENT®