



# Personal Health Questionnaire

First Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Middle Initial \_\_\_\_\_

CIGNA Healthcare ID# \_\_\_\_\_

Last Name \_\_\_\_\_

Employee ID \_\_\_\_\_

Questions 1 - 4: Check ALL that apply

**1. Do you have a personal history of:**

- Diabetes
- Congestive Heart Failure
- High Blood Pressure
- High Cholesterol (Lipid Lowering)
- Low Back Pain
- Asthma
- Stress and Anxiety
- Depression
- None

**2. Do you have a family history of:**

- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol (Lipid Lowering)
- Depression
- None

**3. How would you describe your tobacco use:**

- Cigarettes
- Cigar(s)
- Pipe(s)
- Smokeless (i.e. chewing tobacco and snuff)
- None

**4. Are you currently taking medications for any of the following?**

A)

- Diabetes
- Congestive Heart Failure
- High Blood Pressure
- High Cholesterol (Lipid Lowering)
- Depression
- Stress and Anxiety
- Asthma
- None

**Or are you taking any of the following?**

B)

- Over The Counter (i.e. Baby Aspirin, Cold Medications, etc)
- Nutritional Supplements (Glucosamine, St John's Wart, etc)
- Vitamins
- None

Questions 5 - 12: Check only ONE

**5. How many medications are you currently taking?**

- 1-2
- 3-4
- None

**6. Are you pregnant?**

- Yes
- No

**7. Do you have a pacemaker?**

- Yes
- No

**8. In an average week, how many times do you engage in moderate physical activity that is done for at least 30 minutes?**

- Less than 1 time per week
- 1 or 2 times per week
- 3 or more times per week
- None

**9. How many servings of food do you eat per day that are high in fiber? For example: fruits, vegetables, or whole grain breads?**

- 1 or 2 servings per day
- 3 or more servings per day
- None

**10. How many servings of food do you eat per day that are high in cholesterol or fat? For example: red meat, dairy, shellfish, processed or fried foods?**

- 1 or 2 servings per day
- 3 or more servings per day
- None

**11. Considering your age, how would you describe your overall physical health?**

- Poor
- Fair
- Good
- Very Good
- Excellent

**12. Have you seen your personal physician in the last year?**

- Yes
- No
- I don't have one

Check appropriate box in A and B and total your score.

**13. Over the last two (2) weeks, how often have you been bothered by any of the following problems?**

**A) Little interest or pleasure in doing things?**

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

**B) Feeling down, depressed or hopeless?**

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

Total Score \_\_\_\_\_ (out of a possible 6)

Check appropriate box and write down your total score.

**14. In the past four (4) weeks, how frequently did you feel that your problems were too much to deal with?**

- 0 - None of the time
- 1 - A little of the time
- 2 - Some of the time
- 3 - Most of the time
- 4 - All of the time

Total Score \_\_\_\_\_ (out of a possible 4)

**For Internal Use Only**

Gender \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_ Fasting Glucose \_\_\_\_\_ N/F Glucose \_\_\_\_\_

TC \_\_\_\_\_ HDL \_\_\_\_\_ Risk Ratio \_\_\_\_\_ LDL \_\_\_\_\_ Triglycerides \_\_\_\_\_

Blood Pressure (S) \_\_\_\_\_ (D) \_\_\_\_\_ Waist Circumference \_\_\_\_\_ BMI \_\_\_\_\_ % Body Fat \_\_\_\_\_

Best Phone # \_\_\_\_\_ Alt Phone # \_\_\_\_\_ Best Day to Call \_\_\_\_\_ Best Time \_\_\_\_\_ am / pm

HC opt out