



Personal Health Questionnaire

First Name _____
 Middle Initial _____
 Last Name _____

Date of Birth _____
 Insurance ID _____
 Employee ID _____

1. Do you have a personal history of:

- Diabetes
- Congestive Heart Failure
- High Blood Pressure
- High Cholesterol
- None

2. Do you have a family history of:

- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- None

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

- A)
- Diabetes
 - Congestive Heart Failure
 - High Blood Pressure
 - High Cholesterol (Lipid Lowering)
 - None

Or 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

4. Are you pregnant?

- Yes
- No

5. Do you have a pacemaker?

- Yes
- No

6. 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

7. 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

8. 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

9. How would you describe your tobacco use:

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

10. How would you describe your overall physical health?

- Poor
- Fair
- Good
- Excellent

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

11. 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.

12. 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 _____

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

Best Phone # _____ Alt Phone # _____ Best Day to Call _____ Best Time _____ am / pm

HC opt out