M E D I C A L   H I S T O R Y   I N V E N T O R Y

Male Version

Employees completing the Health Risk Appraisals submit them in sealed envelopes to the front desk at the Community Center. The envelopes are marked confidential and delivered directly to the Health and Wellness Coordinator for log in. Employees are then identified solely by a numbering system on the Health Appraisal Form to provide additional privacy. The forms are shredded after input.

If employees desire, they may leave questions blank and directly input them into the computer system when having their Fitness Assessment. Ultimately, employees also have the choice of not answering all the questions under the cancer risk section. This will, however, result in the Cancer Risk section of the Personal Profile report being omitted.

The purpose of this questionnaire is to enable the staff of the James-City/Williamsburg Community Center to evaluate your health and fitness status and provide you with information to assist you in improving your health. Please answer the following questions to the best of your knowledge. All information given is **CONFIDENTIAL**. Please note that questionnaire is broken up into the subject categories of Heart Disease, Cancer, Diabetes, Stress, Depression, Nutrition, Prevention, and Safety. Each question in the category must be answered to get an evaluation for that category. If you are compelled to skip a question, you will not get an evaluation for that subject. It is recommended that you have physician clearance prior to beginning any new exercise program.

Name:________________________________Age:__________Date of Birth: _______________
Work Address:____
Home Address:____
Work Phone:______________________________Home phone__________________________
Name and Number of Your Physician:____
Name of Person to Contact in Case of Emergency: _____________________________________
Phone Number:________________________Relationship: ______________________________

Medical History

Do you have or have you every had any of the following conditions? (Please write the date when you had the condition in the blank).

_____ Heart murmer, clicks, or other cardiac findings?
_____ Frequent extra, skipped, or rapid heartbeats?
_____ Chest Pain or Angina (with or without exertion)?
_____ Pregnancy (at present)?
_____ Diagnosed high blood pressure?
_____ Heart attack or any cardiac surgery?
_____ Leg cramps (during exercise)?
_____ Chronic swollen ankles?
_____ Frequent dizziness/fainting?
_____ Musculoskeletal/Orthopedic problems?
_____ Diabetes?

_____ Asthma?
_____ Bronchitis?
_____ Cancer?
_____ Stroke?
_____ Emphysema?
_____ Epilepsy?
_____ Rheumatic Fever?
_____ Chronic back pain?
_____ Pneumonia?
_____ Blood Clots?

Do you have or have you been diagnosed with any other medical condition not listed?
____
Please provide any additional comments/explanations of your current or past medical history.
____
Please list any recent surgery (i.e., type, date, etc.) ____
Please list any allergies you may have.____

List all prescribed and non-prescribed medications that you currently take: __________________
____
Are you currently experiencing any health problems? If so, please explain.____
Do you know of any medical problem that might make it dangerous or unwise for you to participate in vigorous exercise?_____If yes, please explain:______________________________
____

Health Inventory

Height (in.) _____ Weight (lbs) _____

Do you currently follow a special diet or weight reduction program? If so, explain:___________
____

Exercise History

Do you currently exercise on a regular basis? Yes _____ No _____ If yes, respond to the following:

Number of exercise sessions per week?____
Duration of each exercise session?____
What type of exercise do you do?____
What type of exercise do you enjoy ?____

If you do not exercise on a regular basis, when was the last time you exercised and what was the type of exercise you performed.____
____
____
____
____
____

Goals and Education

What would you like to accomplish through this exercise program?________________________
____
____
____
____
____
____
____
____

HEALTH CONSIDERATIONS DURING PARTICIPATION IN THE FITNESS ASSESSMENT

It is possible that certain unhealthy changes may occur during the Fitness Assessment. They include abnormal blood pressure, fainting, disorder of heartbeat, and in rare instances, heart attack or stroke.

Information you possess about your health status or previous experiences of unusual feelings with physical effort may affect the safety and value of your evaluation. Your prompt reporting of feelings with effort during the evaluation are also of great importance. You are responsible to fully disclose such information when requested by the testing staff.

Any questions about the procedures used in the evaluation are encouraged. If you have any doubts or questions, please ask us for further explanations.

You are free to stop the evaluation at any point, if you so desire.

I have read this form and I understand the testing procedures that I will perform.

____ ___________________
Signature Date

____
Witness

Health Risk Appraisal Questionnaire - Heart Disease

1. Have you been diagnosed with heart disease?

   ☐ Yes ☐ No

2. Has a parent, brother, or sister ever been diagnosed with heart disease?

   ☐ Yes ☐ No

3. Have you been told by your doctor that you have diabetes?

   ☐ Yes ☐ No

4. How often do you engage in aerobic exercise (walking, jogging, biking, etc.)?

   ☐ Rarely or never
   ☐ 1 to 2 times each week
   ☐ 3 or more times each week

5. Are you currently taking anti-hypertensive medications?

   ☐ Yes ☐ No

6. What is your current Cigarette Smoking habit?

   ☐ I do not smoke cigarettes
   ☐ Smoke less than a pack a day
   ☐ Smoke about a pack a day
   ☐ Smoke two or more packs a day
   ☐ I do not smoke cigarettes, but I use other tobacco products

7. Which statement best describes your Blood Pressure?

   ☐ Normal or low
   ☐ Borderline High
   ☐ High
   ☐ I'm not sure

8. Which statement best describes your Total Cholesterol?

   ☐ Normal or low
   ☐ Borderline high
   ☐ High
   ☐ I am not sure

9. Which statement best describes your HDL Cholesterol?

   a. Low (Bad)
   b. Borderline
   c. High (Good)
   d. I am not sure

Health Risk Appraisal Questionnaire – Cancer

1. Have you been exposed to any of the following:

   ☐ Mining
   ☐ Asbestos
   ☐ Uranium and radioactive products
   ☐ None of the above.

2. Do you smoke?

   ☐ Yes ☐ No **(If answering no, skip to question #8)**

3. What do you smoke?

   ☐ Cigarette or little cigars
   ☐ Pipe and/or cigar, but not cigarettes
   ☐ Nonsmoker

4. How many cigarettes do you smoke per day?

   ☐ 0
   ☐ less than ½ pack per day
   ☐ ½ - 1 pack
   ☐ 1 - 2 packs
   ☐ 2+ packs

5. What type of cigarettes do you smoke?

   ☐ High tar/nicotine
   ☐ Medium tar/nicotine
   ☐ Low tar/nicotine
   ☐ Nonsmoker

6. How long have you smoked?

   ☐ Nonsmoker
   ☐ Up to 15 years
   ☐ 15 - 25 years

- ☐ 25+ years

7. I am stopping smoking today.

- ☐ Yes
- ☐ No
- ☐ Not applicable

8. Has anyone in your family had any of the following:

- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Neither

9. Have you ever had any of the following:

- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Ulcerative colitis for more than seven years
- ☐ Cancer of the breast, ovary, uterus, or stomach
- ☐ None of the above

10. Do you have bleeding from the rectum?

☐ Yes ☐ No

11. Have you had a change in bowel habits (such as altered frequency, size, consistency, or color of stool)?

☐ Yes ☐ No

12. I have altered my diet to contain less fat and more fruits, fiber, and cruciferous vegetables (broccoli, cabbage, cauliflower, brussel sprouts)?

☐ Yes ☐ No

13. Testing for blood in my stool within the past year:

- ☐ I have had a negative exam.
- ☐ I have had a positive exam.
- ☐ I have not had a test for blood in my stool in the past year.

14. Testing for colon cancer and polyps within the past year (procosigmoidoscopy, barium enema x-rays):

- ☐ I have not had a negative exam.
- ☐ I have had a positive exam.
- ☐ I have not had a test for colon cancer and polyps in the past year.

15. Do you live in the southern part of the United States?

☐ Yes ☐ No

16. Do you frequently work or play in the sun?

☐ Yes ☐ No

17. Do you have fair complexion or freckles; (natural hair color of blonde, red, or light brown, or eye color of gray, green, blue, or hazel)?

☐ Yes ☐ No

18. Do you work in mines, around coal tars, or radioactivity?

☐ Yes ☐ No

19. Did you experience a severe, blistering sunburn before the age of 18?

☐ Yes ☐ No

20. Do you have any family members with skin cancer or history of melanoma?

☐ Yes ☐ No

21. Have you had skin cancer or melanoma in the past?

☐ Yes ☐ No

22. Do you use or have you used tanning beds or sun lamps?

☐ Yes ☐ No

23. Do you have any large, many, or changing moles?

☐ Yes ☐ No

24. I cover up with a wide-brimmed hat and wear long-sleeved shirts and pants?

☐ Yes ☐ No

25. I use sunscreens with a SPF rating of 15 or higher when going out in the sun?

☐ Yes ☐ No

26. I examine my skin once a month for changes in warts or moles?

☐ Yes ☐ No

27. Race

☐ Oriental
☐ Hispanic
☐ Black
☐ White

Health Risk Appraisal Questionnaire - Diabetes

1. Have you been diagnosed with diabetes by your physician?

☐ Yes ☐ No

2. I get little or no exercise during a usual day.

☐ Yes ☐ No

3. Have you ever experienced any of the following:

☐ Extreme thirst
☐ Frequent urination
☐ Extreme fatigue
☐ Blurry vision from time to time
☐ Unexplained weight loss
☐ None of the above

4. I have a sister or brother with diabetes.

☐ Yes ☐ No

5. I have a parent with diabetes.

☐ Yes ☐ No

Health Risk Appraisal Questionnaire – Stress

1. I am "calm, cool, and collected".

☐ Almost never
☐ Sometimes
☐ Often
☐ Almost always

2. I feel problems are piling up so that I cannot overcome them.

☐ Almost never
☐ Sometimes
☐ Often
☐ Almost always

3. I feel my heart racing or pounding without exercise.

☐ Almost never
☐ Sometimes
☐ Often
☐ Almost always

4. Some unimportant thought runs through my mind and bothers me.

☐ Almost never
☐ Sometimes
☐ Often
☐ Almost always

5. I feel secure and at ease.

☐ Almost never
☐ Sometimes
☐ Often
☐ Almost always

6. I feel I am losing out because I can't make up my mind.

☐ Almost never
☐ Sometimes
☐ Often
☐ Almost always

7. I feel dizzy, light-headed, or faint.

☐ Almost never
☐ Sometimes
☐ Often
☐ Almost always

8. I wish I could be as happy as others seem to be.

☐ Almost never
☐ Sometimes

- ☐ Often
- ☐ Almost always

9. I feel joyful and confident.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

10. I feel worried and tense.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

11. I am afraid of people and things.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

12. I have stomach pains or indigestion.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

13. I am inclined to take things hard.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

14. I sleep poorly or have nightmares.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

15. I enjoy sitting quietly.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

16. I feel rushed or hurried.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

17. I get headaches or neck pains.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

18. I get flushed or sweaty without exercising or I get hives.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

19. I am eager for new challenges and tasks.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

Health Risk Appraisal Questionnaire - Depression

1. I feel blue or sad.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

2. I feel confident and hopeful about the future.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

3. I feel like a failure.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

4. I don’t enjoy things the way I used to.

- ☐ Almost never

- ☐ Sometimes
- ☐ Often
- ☐ Almost always

5. I feel guilty.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

6. I have a feeling something bad may happen to me.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

7. I am pleased with myself.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

8. I blame myself for everything that goes wrong.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

9. I have crying spells.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

10. I get irritated or annoyed.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

11. I am interested in people and enjoy being with them.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

12. I am unsure of myself and try to avoid decisions.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

13. I feel that I look attractive and healthy.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

14. I sleep poorly and am tired in the morning.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

15. I am energetic and eager to take on new tasks.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

16. My appetite is not as good as it used to be.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

17. I am as interested as sex as I used to be.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

18. I am concerned about my stomach and my <u>bowels</u>.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

19. I feel healthy.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

20. I have trouble working.

- ☐ Almost never
- ☐ Sometimes
- ☐ Often
- ☐ Almost always

Health Risk Appraisal Questionnaire - Nutrition

1. How many caffinated drinks (coffee, tea, cocoa, soft drinks) do you have in typical day?

- ☐ 0
- ☐ 1 to 2
- ☐ 3 to 4
- ☐ 5+

2. How many glasses (8 ounces) of water do you drink in a typical day?

- ☐ 0 to 3
- ☐ 4 to 5
- ☐ 6 to 7
- ☐ 8+

3. My meat/protein eating habit is:

- ☐ Eat regular cuts of red meat, hamburger, wieners, and lunch meat.
- ☐ Eat a mixture of red meats and some poultry or fish.
- ☐ Eat only lean meats, skinless poultry or fish.
- ☐ Eat very little red meat, mostly white meat (poultry or fish)
- ☐ Seldom or never eat meat - I eat mostly vegetables.

4. My diary product/egg eating habit is:

- ☐ Nearly always eat high fat (ice cream, eggs, butter, cheese, etc.)
- ☐ Eat mostly high fat, some low fat (skim milk, yogurt, egg whites)
- ☐ Eat both high fat and low fat about the same.
- ☐ Eat primarily low fat products, but some high.
- ☐ Eat only low fat products or none at all.

5. My dessert eating habit is:

- ☐ Nearly always eat high fat (cake, donuts, pies, ice cream, etc.)
- ☐ Eat mostly high fat, some low (fruits, gelatins, home baked)
- ☐ Eat both high fat and low fat about the same.
- ☐ Eat primarily low fat products, but some high.
- ☐ Eat only low fat products or none at all.

6. My cooking fat/food preparation is:

- ☐ Nearly always cook/eat high fat (fry, shortening, butter creams).
- ☐ Cook/eat food mostly the high fat way.
- ☐ Food cooked both high and low fat (broil, bake, boil, no added fat).
- ☐ Food cooked primarily the low fat way.
- ☐ Food cooked only the low fat way.

7. My bread/grain eating habit is:

- ☐ Nearly always eat refined (white bread, rolls, crackers, cereal)
- ☐ Eat mostly refined grain products.
- ☐ Eat a mixture of refined and whole grain products.
- ☐ Eat primarily whole grain products.

8. My fruits/vegetables eating habit is:

- ☐ Five or more servings per day.
- ☐ Four servings per day.
- ☐ Three servings per day.
- ☐ Two servings per day.
- ☐ One or less servings per day.

9. My fast food eating habit is:

- ☐ I eat fast food nearly every day.
- ☐ I eat fast food several times each week.
- ☐ I eat fast food few times each month
- ☐ I seldom or never eat fast food.

10. My salty food habit is:

- ☐ I seldom or never eat salty food (chips, pickles, added salt).
- ☐ Occasionally I eat salty foods.

☐ I regularly eat salty food.
☐ I frequently eat salty foods - I like salt.

11. My breakfast eating habit is:

☐ I eat a rounded breakfast (more than coffee and roll) daily.
☐ I eat a rounded breakfast almost every day.
☐ I sometimes eat a rounded breakfast.
☐ I rarely eat breakfast.

12. My high fat snack eating habit is:

☐ I eat high fat snack foods (potato chips) 3 or more times daily.
☐ I eat high fat snacks once or twice daily.
☐ I eat high fat snacks few times each week.
☐ I rarely or never eat high fat snacks.

Health Risk Appraisal Questionnaire - Prevention

1. Do you have a source of professional medical care?

☐ Yes ☐ No

2. Do you feel comfortable discussing health problems with your health care provider?

☐ Yes ☐ No

3. Have you had your vision/hearing checked in the past 5 years.

☐ Yes ☐ No

4. Do you have a rectal exam annually?

☐ Yes ☐ No

5. Have you had your blood pressure checked in the past year?

☐ Yes ☐ No

6. Have you had your blood cholesterol checked in the past year?

☐ Yes ☐ No

7. How often do you have medical checkups?

☐ Never
☐ Only when I'm sick.
☐ Every 5 or more years.
☐ Every 3 to 5 years.
☐ Every 1 to 3 years.
☐ Annually.

8. Do you wear protective clothing or use sunscreen with a SPF rating of 15 or higher when going out in the sun.

☐ Yes ☐ No

9. Do you examine your skin once a month for changes in warts or moles.

☐ Yes ☐ No

10. Do you examine your testicles for lumps every month

☐ Yes ☐ No

11. Do you have a rectal and prostate exam annually?

☐ Yes ☐ No

Health Risk Appraisal Questionnaire - Safety

1. How many miles per year do you travel in a car?

☐ Over 25, 000 miles.
☐ 20,000 to 25,000 miles.
☐ 10,000 to 20,000 miles.
☐ 5,000 to 10,000 miles.
☐ Less than 5,000 miles.

2. How often do you wear your seat belt while in a car?

☐ Seldom wear my seat belt.
☐ Occasionally.
☐ At least half the time.
☐ Most of the time.
☐ All of the time.

3. Do you drive within the speed limit?

- ☐ Yes always.
- ☐ Most of the time.
- ☐ Often drive a little over.
- ☐ Often drive more than 5 mph over.
- ☐ Often drive more than 10 mph over.

4. Do you ride in a car when the driver is intoxicated?

- ☐ Never
- ☐ Seldom, but have on occasion.
- ☐ Occasionally, once a month or so
- ☐ Often, more than twice a month.

5. I wear a helmet while riding a bike or motorcycle.

- ☐ Yes
- ☐ No
- ☐ Not applicable.

6. I store chemical household products/medications out of the reach of children.

☐ Yes ☐ No

7. I store products marked "Danger" or "Poison" in a locked storage area.

☐ Yes ☐ No

8. I store products marked "Flammable" in a shed or lock box outside of my home and garage.

☐ Yes ☐ No

9. I carefully read labels and follow instructions when using chemical household products.

☐ Yes ☐ No

10. I have working smoke detectors on every floor in my home that are checked regularly.

☐ Yes ☐ No

11. I have emergency numbers (doctors, emergency room, poison control, 911) listed on or near each phone in my home?

☐ Yes ☐ No

12. I have a home evacuation plan in case of fire, natural disaster, or other emergency.

☐ Yes ☐ No

13. My home evacuation plan is practiced as least every six months.

☐ Yes ☐ No

14. I have a working fire extinguisher in my home.

☐ Yes ☐ No

15. I am trained in CPR and know basic first aid.

☐ Yes ☐ No

16. I know where the gas and water utility valve switches are located for my home and know how to shut them off.

☐ Yes ☐ No

17. Each bathtub and bathroom floor in my home is covered with a non-skid surface or rubber mat.

☐ Yes ☐ No

18. The water heater for my home is set to keep the hot water temperature at 120 F or less to prevent scalds and burns.

☐ Yes ☐ No

19. Hallways and stairs in my home are well lit.

☐ Yes ☐ No

20. My home is "smoke free" - no cigarettes, pipes or cigars are smoked inside.

☐ Yes ☐ No

21. Hallways, doors, and stairs in my home are clear of obstacles such as furniture, boxes, toys, electric cords, etc.

☐ Yes ☐ No

22. I practice techniques that will prevent injury from repetitive activities (working on a keyboard, bending over, sitting at a desk).

☐ Yes ☐ No

23. I practice proper lifting techniques? (Bend your knees and squat close to the load, and rely on your thighs and abdominal muscles to do most of the lifting).

☐ Yes ☐ No