



Today's Date

Location

Age Male Female

Last 4 Digits of SSN

Birthdate (MM/DD/YYYY)

First Name

Last Name

Street

City

State Zip

Site Code: **3018**

Please answer every question carefully by filling in the square next to your answer with a heavy mark. If you make a mistake, please erase it completely and fill in the correct answer.

Version: **HPP ONLY WITH LAB VALUES**

IDENTIFICATION

1. Please enter your EBT Member ID# (9-digit number that starts with "9" on your Member ID card)

 9 _____

BIOMETRICS

1. Please enter your height in feet and inches.

2. Please enter your weight in pounds.

3. Please enter your **Systolic** Blood Pressure value.

4. Please enter your **Diastolic** Blood Pressure value.

Blood Pressure

Your Blood Pressure reading contains two values and might look like this example:

115/78.

The first value (115 in the example) is called the **Systolic** value.

The second value (78 in the example) is called the **Diastolic** value.

If you do not know your actual Blood Pressure values, skip questions 3 & 4 and proceed to question 5.

5. If you were not able to provide the actual values for your blood pressure in the previous questions, please complete the following statement:

"Generally, my blood pressure is:"

- High
 Average
 Low
 Don't Know

Lab Values

Your Total Cholesterol, HDL & LDL Cholesterol, Triglycerides and Glucose values are all important lab measures considered in the Health Power Profile.

If you have had lab work completed recently and know the actual lab values, please enter them where requested.

6. Your most recent Total Cholesterol value was:

Total Cholesterol Value

If you do not know your actual Total Cholesterol value, skip this question.

7. Your most recent HDL Cholesterol value was:

HDL Cholesterol

If you do not know your actual HDL Cholesterol value, skip this question.

8. Your most recent LDL Cholesterol value was:

LDL Cholesterol

If you do not know your actual LDL Cholesterol value, skip this question.

9. Your most recent Triglycerides value was:

Triglycerides

If you do not know your actual Triglycerides value, skip this question.

10. Your most recent Glucose value was:

Glucose

If you do not know your actual Glucose value, skip this question.

Estimated Lab Values

If you were not able to provide any of the actual lab values in questions 6 - 10, please complete questions 11 - 15.

11. If you were not able to provide the actual value for your Total Cholesterol in question #6, please complete the following statement:

Generally, my Total Cholesterol is:

- High
 Average
 Low
 Don't Know

—
If you already answered question 6 with an actual Total Cholesterol value, you can skip this question.

12. If you were not able to provide the actual value for your HDL Cholesterol in question #7, please complete the following statement:

Generally, my HDL Cholesterol is:

- High
 Average
 Low
 Don't Know

—
If you already answered question 7 with an actual HDL Cholesterol value, you can skip this question.

13. If you were not able to provide the actual value for your LDL Cholesterol in question #8, please complete the following statement:

Generally, my LDL Cholesterol is:

- High
 Average
 Low
 Don't Know

—
If you already answered question 8 with an actual LDL Cholesterol value, you can skip this question.

14. If you were not able to provide the actual value for your Triglycerides in question #9, please complete the following statement:

Generally, my Triglycerides are:

- High
 Average
 Low
 Don't Know

—
If you already answered question 9 with an actual Triglycerides value, you can skip this question.

15. If you were not able to provide the actual value for your Glucose in question #10, please complete the following statement:

Generally, my Glucose is:

- High
 Average
 Low
 Don't Know

—
If you already answered question 10 with an actual Glucose value, you can skip this question.

NUTRITION

1. How many servings of fruits (1 piece or 1/2 cup) do you eat each day?

- 0-1 servings
 2 servings
 3 servings
 4 servings
 5 servings

2. How many servings (1/2 cup) of vegetables do you eat each day?

- 0-1 servings
 2 servings
 3 servings
 4 servings
 5 servings

3. How many servings of high-fiber whole grain foods (1/2 cup) do you eat each day?

- 0-3 servings
 4-5 servings
 6-7 servings
 8-9 servings
 10 or more servings

One Serving Size =

Whole grain (unbleached) breads, bagels, cereals, pastas, rices & other foods made from whole grains that are unbleached.

- 1 small bowl of whole grain cereal, granola
 1 slice whole wheat bread, multi-grain bread, high-fiber bread
 1/2 cup cooked oatmeal, brown or wild rice, whole grain pasta
 1/2 cup cooked navy, garbanzo, kidney and other beans

4. How many servings of high-fat foods do you eat each day?

- 0-1 servings
 2-3 servings
 4-5 servings
 6-7 servings
 8 or more servings

One Serving Size =

Foods or dishes cooked in or including large portions of the following fats:
 Butter, margarine, cooking oil, lard

1 small bag or handful of:
 French fries, onion rings, potato chips, Cheetos, Fritos, nachos, buttered popcorn, fish sticks, tater tots

1 oz of:
 Cheese, cream cheese, alfredo sauce, cooking oil, butter, margarine, salad dressing, sour cream

2 pieces of:
 Sausage, bacon, chicken with skin

1 standard:
 Hamburger, cheeseburger, steak, pork chop, hot dog, bratwurst, twinkie, cupcake, piece of cake

1 cup of:
 Regular ice cream, milk shake, egg nog

5. How many servings of milk, yogurt, cheese or other calcium-rich foods do you eat each day?

- 0-1 servings
 2 servings
 3 servings
 4 or more servings

6. In general, do you eat a healthy breakfast almost every day?

- No
 Yes

A Healthy Breakfast =

A healthy breakfast includes one item from at least three of the following food groups:

Fruits and Vegetables:

Fresh fruits and vegetables, 100% juice, a fruit cup without added sugar

Whole Grains:

Rolls, bagels, hot or cold whole-grain cereals

Dairy:

A small glass of milk, low-fat yogurt, low-fat cheeses

Protein:

Eggs (scrambled, poached or boiled), peanut butter, lean meat, poultry or fish

7. How many servings of sweets, candy and beverages with sugar (e.g., regular soda, juices, coffee, tea, hot chocolate) do you consume each day?

- 0-1 servings
 2 servings
 3 servings
 4 servings
 5 or more servings

One Serving Size =

One serving of sugar includes:

- 1 small piece of cake
- 1 regular size candy bar
- 1 regular soda, pop or juice drink
- 1-2 cookies
- 3-5 pieces of small hard candy

Note: the USDA recommends no more than 1- teaspoons of sugar per day (1 teaspoon = 4 grams)

For example, a 12oz. Pepsi® contains 10 teaspoons of sugar.

8. On average, how many 8 oz. glasses of water do you drink each day?

- 0-1 glasses
 2-3 glasses
 4-5 glasses
 6-7 glasses
 8 or more glasses

9. How ready are you to eat healthier foods?

- I haven't thought about changing
 I plan to change within 6 months
 I plan to change this month
 I recently started doing this
 I do this regularly/already

FITNESS

1. In the past 6 months, how many times per week did you participate in 20 or more minutes of aerobic exercise?

- 0 days
 1-2 days
 3-4 days
 5-6 days
 7 days

Examples of Aerobic Exercise

Any continuous exercise that increases your heart rate & breathing rate:

Walking, hiking, jogging, running, swimming, bicycling, basketball, soccer, cross-country skiing, stair-stepper, aerobic dance, square dancing, other dancing

2. In the past 6 months, how many times per week did you participate in strength building (weight or resistance training) exercise?

- 0 days
 1-2 days
 3-4 days
 5-6 days
 7 days

3. In the past 6 months, how many times per week did you participate in stretching (flexibility) exercise?

- 0 days
 1-2 days
 3-4 days
 5-6 days
 7 days

4. How ready are you to exercise more?

- I haven't thought about changing
 I plan to change within 6 months
 I plan to change this month
 I recently started doing this
 I do this regularly/already

5. How ready are you to reach and maintain your ideal weight?

- I haven't thought about changing
 I plan to change within 6 months
 I plan to change this month
 I recently started doing this
 I do this regularly/already

ALCOHOL

1. Do you drink alcoholic beverages?

- Yes
 No

One Serving of Alcohol =

Beer, wine, wine coolers, mixed drinks, shots or holiday punches and other mixed beverages with alcohol in the recipe:

- 1 can or glass of beer
- 1 glass of wine
- 1 wine cooler
- 1 mixed drink
- 1 shot of hard liquor
- 1 cup of punch (with alcohol)

2. On average, when you drink alcohol, how many servings do you drink per day?

- 1-2 servings
 3-4 servings
 5-6 servings
 7-8 servings
 9 or more servings

3. What is the most number of servings of alcohol you drink in one day?

- 1-2 servings
 3-4 servings
 5-6 servings
 7-8 servings
 9 or more servings

4. On average, how many days a week do you drink alcohol?

- 0-1 days
 2 days
 3 days
 4 days
 5 days
 6-7 days

5. How ready are you to drink less alcohol or none at all?

- I haven't thought about changing
 I plan to change within 6 months
 I plan to change this month
 I recently started doing this
 I already drink little or no alcohol

SAFETY

1. In the past month, how frequently did you ride with someone who had too much to drink, or drive when you had too much to drink?

- Never
 Sometimes
 Often
 Very Often
 Always

2. How often do you wear a seat belt when driving or riding in a motor vehicle?

- Never
 Sometimes
 Often
 Very Often
 Always

3. On average, how frequently do you drive at or below the speed limit?

- Never
 Sometimes
 Often
 Very Often
 Always

4. I practice proper lifting and other strategies to keep my back safe, healthy and comfortable.

- Never
 Sometimes
 Often
 Very Often
 Always

HYGIENE & IMMUNIZATIONS

1. I wash/clean my hands several times a day, including after using the bathroom, after sneezing or coughing into my hands.

- Never
 Sometimes
 Often
 Very Often
 Always

2. I've had a tetanus shot within the last 10 years.

- No
 Yes

What is a Tetanus Shot?

The Tetanus vaccine is necessary to prevent infection whenever a deep wound may have been contaminated with soil -- where Tetanus-causing bacteria can be found. Tetanus boosters are recommended for adults every 10 years, or at the time of a major injury if it has been more than 5 years since the last booster.

3. I have a flu shot every year.

- No
 Yes

HEALTH CARE

1. I do the recommended monthly self-exams to detect potential health problems as early as possible.:

- Never
 Sometimes
 Often
 Very Often
 Always

What are the Self-Exams?

Women should do a regular breast self-exam.

Men should do a regular testicular self-exam.

Everyone should do an overall skin check including the scalp and inside of the mouth.

2. When was the last time you saw a medical doctor for a checkup or physical exam?

- Within the last 12 months
 Within the last 1-2 years
 Within the last 3-4 years
 Within the last 5-6 years
 7 or more years ago

3. Do you currently have a personal or family doctor to see for routine (primary) health care? (e.g., doctors in family practice or internal medicine, or OB/GYN)

- Yes
 No

4. Do you (or will you) share your screening results with your primary care doctor?

- Yes
 No

5. Which of the following conditions do you currently have: (check all that apply)

- High blood pressure
 High cholesterol
 Diabetes
 Depression
 Heart Condition
 Asthma
 Pregnancy
 Chronic pain
 Cancer
 COPD

6. I'm currently receiving health care for the following conditions: (check all that apply)

- High blood pressure
 High cholesterol
 Diabetes
 Depression
 Heart condition
 Asthma
 Pregnancy
 Chronic Pain
 Cancer
 COPD

HYGIENE & IMMUNIZATIONS

1. How ready are you to take steps to improve your resistance to germs?

- I haven't thought about changing
 I plan to change within 6 months
 I plan to change this month
 I recently started doing this
 I do this regularly/already

TOBACCO

1. What describes your use of tobacco products?

- Current tobacco user
 Former tobacco user
 Never used any kind of tobacco.

2. What statement best describes your cigarette-smoking habit?

- I have never smoked cigarettes
 I quit smoking cigarettes a year or more
 I quit smoking less than a year ago

3. In an average week, how often do you use chewing tobacco?

- I do not use it
 1-2 days
 3-4 days
 5-6 days
 7 days

4. In an average week, how often do you smoke cigars or pipe tobacco?

- I do not smoke them
 1-2 days
 3-4 days
 5-6 days
 7 days

5. On an average day, how many cigarettes do you smoke?

- I do not smoke any
 1/2 pack or less
 1 pack
 2 packs
 3 or more packs

6. Which statement best describes how you feel about your use of tobacco?

- I have no plans to quit using tobacco
 I need ideas for better controlling my
 I plan to quit using tobacco in the next 6
 I plan to quit in the next month

RESILIENCE

1. I have a strong network of supportive family and/or friends.

- No
 Yes

2. I seek information and/or assistance with important (or difficult) decisions, tasks or problems.

- Never
 Sometimes
 Often
 Very Often
 Always

3. I make time each day for quiet relaxation time, meditation and/or daily prayer.

- Never
 Sometimes
 Often
 Very Often
 Always

4. I belong to a faith community. (e.g., church, synagogue, temple, mosque, etc.)

- Yes
 No
 I prefer not to answer this question

5. I have at least one best friend at work.

- No
 Yes

6. I get at least 7-8 hours of sleep each night.

- Never
 Sometimes
 Often
 Very Often
 Always

PERCEPTIONS

1. I feel depressed, down, or "blue".

- Never
 Sometimes
 Often
 Very often
 Always

2. How often do you feel tense or anxious?

- Never
 Sometimes
 Often
 Very often
 Always

3. The stress or pressures in my life seem out of control.

- Never
 Sometimes
 Often
 Very Often
 Always

4. How ready are you to try to handle stress better?

- I haven't thought about changing
 I plan to change within 6 months
 I plan to change this month
 I recently started doing this
 I already handle stress well

5. Have you suffered a personal loss or misfortune in the past year? (e.g., a job loss, disability, divorce, separation, jail term or death of someone close to you)

- Yes, two or more serious losses
 Yes, one serious loss
 No

6. In general, how satisfied are you with your life? (include personal and professional aspects)

- Completely satisfied
 Mostly satisfied
 Partly satisfied
 Not satisfied

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

- Excellent
 Very good
 Good
 Fair
 Poor

8. During the past year, how much effect has stress had on your health?

- A lot
 Some
 Hardly any
 None

9. During the past 12 months, how much did your health problems (of self or family) affect your productivity while you were working?

- No health problems
 None of the time
 Some of the time
 Most of the time
 All of the time

10. In the past 12 months, about how many days did you miss work because you or a family member were sick, injured, or needed health care?

- 0 days
 1-2 days
 3-5 days
 6-10 days
 11-15 days
 16 days or more

End of survey.

Thank You!

For completing the Health Power Profile health risk assessment.

Please double check that each question has been answered and all the information has been filled out so we can give you a complete and confidential report.