Health Assessment Questionnaire

Thank you for taking a pro-active approach to your health by participating in your company's wellness assessment. The following questions will cover personal and family health history as well as your current health practices. Please fill out to the best of your ability in order to assist our wellness specialist and nurses with recommendations to help improve your health.

If you have any questions, please feel free to call 800-444-5769.

Please return by mail, fax or e-mail to:

HealthEZ
Attn: Medical Management
P.O. Box 398220
Minneapolis, MN 55439-8220

Fax #: 952-896-1261
E-mail: medical.management@healthez.com

Demographic Information

Are you a health plan member? ❑ Yes ❑ No

Date: _____

Name: _____

Date of Birth: _____

Age: _____

Sex: ❑ Female ❑ Male

Telephone Number: _____

E-Mail Address: _____

What is your job or occupation? _____

Your primary clinic: _____

What is your weight? (in pounds) _____

What is your height? (in inches) _____

Health Assessment Questionnaire Cont.

Medical History (immediate family members include parents and siblings, but not grandparents, uncles, cousins, etc.)

Do you or an immediate family member have a history of Diabetes? ❑ Yes ❑ No

List type if known: _____

Do you or an immediate family member have a history of cardiac disease, such as high blood pressure, high cholesterol, stroke, heart attack, or congestive heart failure? ❑ Yes ❑ No

List type and treatment: _____

Do you or an immediate family member have a history of cancer? ❑ Yes ❑ No

List type and treatment: _____

Do you or an immediate family member have a history of a lung/breathing disorder? ❑ Yes ❑ No

List type and treatment: _____

Do you or an immediate family member have any other serious health conditions? ❑ Yes ❑ No

List type and treatment: _____

Please list any prescription medications you are currently taking: _____

_____

Do you feel you understand the use of each medication? ❑ Yes ❑ No

Lifestyle

Do you use tobacco (e.g. cigarettes, pipes, chewing tobacco)? If yes, how much/day? ❑ Yes ❑ No _____

If a past user, how many years has it been since you used nicotine? _____

List number of servings of fruits & vegetables consumed daily: _____

List number of servings of whole grain foods consumed daily: _____

List number of servings of high fat or high sugar foods or beverages (junk food) consumed daily: _____

How many 8 oz. glasses of water do you drink daily? _____

How many alcoholic beverages do you consume in a typical week? _____

How many times per week do you get 30 minutes or more of moderate - vigorous physical activity? _____

Health Assessment Questionnaire Cont.

Women Only

Are you currently pregnant? ❑ Yes ❑ No What is the estimated due date? _____

Have you had a mammogram? ❑ Yes ❑ No List date and results of last exam: _____

_____

How often do you examine your breasts for lumps? _____

Have you had a pap smear? ❑ Yes ❑ No List date and results of last exam:_____

_____

Men Only

Have you had a prostate exam with PSA test? ❑ Yes ❑ No List date and results of last exam: _____

_____

Men & Women

Have you had a colonoscopy? ❑ Yes ❑ No List date and results of last exam:_____

_____

When was your last general physical exam? _____

Health Goals

Do you wish to lose weight? If yes, how much? ❑ Yes ❑ No _____

Do you wish to stop using tobacco products? ❑ Yes ❑ No

Do you want to eat a healthier diet? ❑ Yes ❑ No

Do you want to begin an exercise program or increase your existing one? ❑ Yes ❑ No

Thank you for completing the wellness questionnaire. HealthEZ's specialists will review your information and send you a personalized health analysis complete with recommendations.