US HealthCenter
PERSONAL • PREDICTIVE • HEALTH

Health Risk Assessment Questionnaire

Instructions

Please follow the instructions below to complete your Health Risk Assessment Questionnaire.

- ✓ All pages of your Questionnaire must be completed.
- ✓ The Questionnaire should be filled out **legibly** using black or blue ink.
- ✓ Make sure your **Username is filled out on every page**.

Your Username is: the first letter of your first name + your entire last name + the last four digits of your social security number (i.e. John Smith = jsmith1482). No spaces, hyphens, commas, etc.

DON'T FORGET TO FAST!

Remember, a 9 hour fast is required before your screening.

Please turn in your completed HRA Questionnaire to the examiner at the time of your biometric screening appointment.

NOTICE REGARDING WELLNESS PROGRAM

The wellness program sponsoring organization ("Sponsor Organization") offers a voluntary wellness program available to a variety of participants which may include (employees/associates, spouses and domestic partners). The program is administered in compliance with federal rules permitting employer-sponsored wellness programs to seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act (HIPAA), as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a ***voluntary*** health risk assessment or "**HRA**" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease).

You may also have the option to complete a biometric screening, which may include a blood test for total cholesterol, HDL, LDL, VLDL, LDL/HDL, total cholesterol/HDL ratio, triglycerides, glucose, creatinine, cotinine, GGT, albumin, alkaline phosphates, bilirubin, BUN, calcium, globulin, SGOT (AST), SGPT (ALT), EGFR, SGOT/SGPT Ratio, total protein, and uric acid. Other tests, which may be available, include a complete blood test panel, thyroid, PSA, and A1C. Additionally, height, weight, wrist, waist measurement, hip measurement and blood pressure are obtained. For specific information regarding the panel of labs offered by the Sponsor Organization, refer to your wellness program materials.

You are not required to complete the HRA or to participate in the blood test or other medical examinations. However, participants who choose to participate in the wellness program will receive an incentive as described in the wellness program communications. Although you are not required to complete the HRA or participate in the biometric screening, only participants who do so will remain eligible for the incentive(s). Please note, however, that the only "mandatory" questions you must answer in order to earn the incentive are your last name, first name, address, city, state, zip, home phone, cell phone, e-mail address, date of birth, ethnicity and gender. All other questions are voluntary. Some questions may ask you about your health status. Answering these questions will help you better assess your future risks and provide additional information for you to share with your own health care provider. Please note, the non-mandatory questions are not required to receive an incentive, if one is available. In particular, the questions in sections 2, 5, 6, 7 and 8 that permit you to provide health status or genetic information are associated with no incentive.

Rewards and incentives, if made available, often are tied to completing a biometric screening and completing the HRA. Other actions or health outcomes may be required, see your program materials for details. If you are unable to participate in any of the health-related activities required to earn a reward or a health outcome, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting US HealthCenter.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as information about online modules and newsletters. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

US HealthCenter is required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program, US HealthCenter and the Sponsor Organization may use aggregate information collected to design a program based on identified health risks in the workplace, US HealthCenter will never disclose any of your personal information either publicly or to the Sponsor Organization, except as necessary to respond to a request from you for a reasonable accommodation (such as a coaching program or cessation program) needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

US HealthCenter is authorized to provide minimal data as necessary to the Sponsor Organization to allow the Sponsor Organization to apply the rewards, if available. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, in the situation of a sale or merger of the wellness company, or with the appropriate signed authorization to release the information You will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

The only individual(s) who will receive your personally identifiable health information includes US HealthCenter and any business associates and health coaches, if assigned, to provide alert value calls or wellness services to the Sponsor Organization. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, you will be notified.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your wellness program administrator (see your program materials for the appropriate person). If you are unsure of who to contact, please call US HealthCenter and we will help connect you with the wellness program administrator at your Sponsor Organization.

____ ACCEPT: I accept the terms and conditions above.
____ DECLINE: I do not wish to participate in the wellness program and understand I will not receive the incentive offered in exchange for my participation. If I participate later, I thereby agree to the terms and conditions as if I initially accepted.

_____ Signature

_____/_____/_____ Date

Today's Date _____/_____/_____

Personal Information

First Name_____ Last Name_____

Address_____ City_____ State _____ Zip Code _____

Date of Birth _____/_____/_____ Phone Number (_____) _____ Gender: □ Female □ Male

Email _____

Company Name _____ Company Location _____

Ethnicity: □ Caucasian/White □ Northern European □ Mediterranean □ African □ African American □ African Caribbean □ Hispanic □ Latin American □ Asian □ Native American □ Mixed □ I don't know □ Other _____

Regarding the sponsor employer's health coverage, are you a … □ Employee □ Spouse □ Dependent (Child) □ Retiree

1. Nutritional and Eating Habits

1.0 Do you frequently eat (4 or more days a week):
□ a. Large portions
□ b. When not hungry
□ c. Skip meals

1.1 My diet is high in:
□ a. Salt
□ b. Fried or Fatty Foods
□ c. Sugar
□ d. Snacks

1.2 My diet is low in:
□ a. Vitamins
□ b. Fiber
□ c. Calcium
□ d. Fruits/Vegetables

1.3 Select your diet:
□ a. Regular
□ b. High Protein
□ c. Vegetarian
□ d. Diabetic
□ e. Fast Food

1.4 To better calculate Body Mass Index (BMI), indicate your body type as one of the following:
□ a. Thin
□ b. Normal
□ c. Lean and Muscular

2. Physical Activity and Safety

2.0 Do you exercise regularly every week? □ I do not □ I do

How often do you do…

	Minutes per session	Days Per Week
2.0.1 Nonstop Intense Aerobic Exercise		
2.0.2 Muscle / Strength Exercise		
2.0.3 Stretching Exercise		
2.0.4 Sustained Moderate Exercise		

2.1 Daily Activity and Safety Your predominant daily activities are:

2.1.1 My daily activities at work are…

□ a. Sitting
□ b. Standing / Stretching
□ c. Moving Around

2.1.2 I'm exposed to the following at work: (check all that apply)

□ 1. Heavy Lifting
□ 2. Risk of Injury
□ 3. Repetitive Motion
□ 4. Kneeling
□ 5. Smoke, Silicone or Dust
□ 6. Asbestos
□ 7. Pesticides, herbicides, Insecticides

2.1.3 My daily activities at home are…

□ a. Prolonged Sitting
□ b. Moving Around
□ c. Heavy Work
□ d. Sports or hobbies that can cause injuries

2.1.4 Safety: (check all that apply)

□ a. No smoke detector
□ b. Frequent joint injuries
□ c. Two or more injuries within 1 year
□ d. Back Injury / Sprain

3. Physical Health

3.0 Rate your present **physical health** □ Excellent □ Good □ Fair □ Poor □ Very Poor

3.1 Rate your current **job satisfaction** □ Excellent □ Good □ Fair □ Poor □ Very Poor

3.2 Does your health interfere with your ability to function…

a. …**At Work**? □ Ususally □ Sometimes □ Never

b. …**At Home**? □ Ususally □ Sometimes □ Never

3.3 Have you had the following vaccinations?

a. Complete Childhood Vaccinations
- ☐ Yes
- ☐ No
- ☐ I don't know

b. Annual Flu Shot
- ☐ Yes
- ☐ No
- ☐ I don't know

c. Tetanus Shot within 10 Years
- ☐ Yes
- ☐ No
- ☐ I don't know

4. Emotional Health

4.0 Rate your current emotional state ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

4.1 Are you energetic, full of life and generally happy? ☐ Yes ☐ No

4.2 In the last year, have you been less socially active with friends, co-workers and /or family? ☐ Yes ☐ No

4.3 In the last year, do you need more than usual emotional support from friends and family? ☐ Yes ☐ No

4.4 Do you feel sad, blue, depressed, or are you losing interest in the things you enjoy? ☐ Yes ☐ No

4.5 Do you feel that life is not worth living? ☐ Yes ☐ No

4.6 Rate your level of daily experience for the following:

a. Stress	☐ None	☐ Low	☐ Moderate	☐ High
b. Anxiety	☐ None	☐ Low	☐ Moderate	☐ High
c. Anger	☐ None	☐ Low	☐ Moderate	☐ High
d. Depression	☐ None	☐ Low	☐ Moderate	☐ High

5. Driving Safety

5.0 Do you wear your seatbelt?	☐ Always	☐ Sometimes	☐ Never
5.1 Do you take unnecessary chances when driving?	☐ Usually	☐ Sometimes	☐ Never
5.2 Do you drive in heavy, bumper to bumper traffic?	☐ Usually	☐ Sometimes	☐ Never
5.3 Do you drive 10+ miles per hour over the speed limit?	☐ Usually	☐ Sometimes	☐ Never
5.4 Do you drive after drinking alcohol?	☐ Usually	☐ Sometimes	☐ Never

6. Skin Health

6.0 Check all that apply

□ a. I am highly exposed to the sun

□ b. I am fair skinned

□ c. I burn easily

□ d. I have had sunburns in the past

□ e. I don't use sun protection

□ f. I have multiple body moles

□ g. I have had a recent change in moles

□ h. I have had multiple skin biopsies

7. Tobacco Use

7.0 Do you use tobacco on a regular basis?

a. □ I never use tobacco products (skip to section 8)

b. □ I presently use tobacco products (skip to question 7.1)

c. □ I quit smoking (skip to question 7.2)

7.1 Present Tobacco Use

Cigarettes

1. Number of cigarettes per day: _____ / day
2. How many Years? _____ years

Cigars, Pipe or Chew

1. Number of times per day: _____ / day
2. How many Years? _____ years

7.2 Past Tobacco Use

Cigarettes

1. I quit: _____ years ago
2. Number of cigarettes per day BEFORE quitting? _____ /day
3. How many years did you smoke before quitting? _____ years

Cigars, Pipe or Chew

1. I quit: _____ years ago
2. Number of times per day BEFORE quitting? _____ /day
3. How many years did you smoke cigars/pipe or chew tobacco before quitting? _____ years

8. Alcoholic Beverages

8.0 Do you consume alcohol?

□ a. I don't drink alcohol *(skip to question 9)*

□ b. I drink alcohol

□ c. I stopped drinking alcohol _____ years ago *(skip to question 8.4)*

8.1 If you drink alcohol, what is the average number of drinks per day? _____ drinks

8.2 In the past month, how many days did you drink

a. If male, 5 or more alcoholic drinks: _____ days

b. If female, 4 or more drinks: _____ days

8.3 How many years have you been drinking alcohol? _____ years

8.4 If you quit, how many years ago did you quit? _____ years ago

9. Medical History

9.1 Have you or are you currently being treated for any of the following conditions? If no, move on to question 10.1. If yes, write the number of years in the space. If yes, and in the last 1-11 months put 0 in the box. Check the corresponding box if using medication for the disease /condition.

Disease / Condition	How Many Years?	On Meds?	Disease / Condition	How Many Years?	On Meds?
□ 1. Allergies		□	□ 18. Hepatitis		□
□ 2. Aortic Aneurism		□	□ 19. High Cholesterol		□
□ 3. Anxiety		□	□ 20. Hypertension		□
□ 4. Arthritis		□	□ 21. Hyperthyroid		□
□ 5. Asthma		□	□ 22. Hypothyroid		□
□ 6. Back Problems		□	□ 23. Irritable Bowel Synd.		□
□ 7. Bleeding Disorder		□	□ 24. Kidney Disease		□
□ 8. Carotid Artery Dis.		□	□ 25. Liver Cirrhosis		□
□ 9. Chronic Cough		□	□ 26. Migraines		□
□ 10. Colon Polyps		□	□ 27. Osteoporosis		□
□ 11. Coronary Disease		□	□ 28. Peripheral Artery Dis.		□
□ 12. Depression		□	□ 29. Psoriasis		□
□ 13. Diabetes I		□	□ 30. Sleep Disorder		□
□ 14. Diabetes II		□	□ 31. Stomach reflux/Ulcer		□
□ 15. Emphysema		□	□ 32. Stroke		□
□ 16. Epilepsy		□	□ 33. Ulcerative Colitis		□
□ 17. Heart Attack		□			

9.2 Do you have the following cancers?

Cancer	How many years?	On Meds?	Cancer	How many years?	On Meds?
□ a. Skin		□	□ d. Lymphoma/Leukemia		□
□ b. Colon		□	□ e. Multiple colon polyps or Familial Polyposis		□
□ c. Lung		□	□ f. Other Cancer		□

9.3 Are you missing any of the following organs from birth or due to surgery? (Check all that apply)

□ a. Both Breasts

□ b. Cervix

□ c. Uterus

□ d. Both Ovaries

□ e. Prostate

□ f. Colon

9.4 Medications

a. How many medications do you take? _____ (If none, skip to question 9.5)

b. Do you take your medications regularly according to directions? □ Yes □ No

c. If you are taking prescription medications, how often do you take all of them exactly as prescribed by your physician?

□ a. Every day (100%)

□ b. Most days (75%)

□ c. Some days (50%)

□ d. On rare days (less than 50%)

□ e. Never

9.5 Allergies

Do you have any of the following allergies? (check all that apply)

□ a. Medications

□ b. Foods

□ c. Peanuts

□ d. Bees

□ e. Pollen

□ f. Dust / Mold

□ g. Animals / Wool

10. Men's Health (Males only)

Men, check all that apply and enter how many years ago in the box. If 1-11 months, put 0.

- □ a. Annual PSA (males over 50)
- □ b. Abnormal Prostate Exam ____ years
- □ c. Transrectal Ultrasound ____ years
- □ d. Prostate Biopsy ____ years
- □ e. Prostate Cancer ____ years
- □ f. Vasectomy ____ years

11. Women's Health (Females only)

11.0 Past / Present Pregnancy. Women, check all that apply:

a Are you pregnant? □ Yes □ No (If no, skip to 11.d)

b If yes, which term? □ 1st □ 2nd □ 3rd

c. If yes, will you have regular OB care? □ Yes □ No

d. Number of previous pregnancies: ____

11.1 Check all that apply:

- □ a. First birth over the age of 30
- □ b. Baby of 9 pounds or more
- □ c. I breast fed
- □ d. Menstrual period before age of 12
- □ e. Menopause after age 54
- □ f. Abnormal vaginal bleeding after menopause
- □ g. Polycystic Ovaries: If yes, how many years ago? If 1-11 months, put 0. ____

11.2 Indicate the number of years, if any, you have had the following. If 1-11 months, put 0.

- □ a. Birth Control Pills ____ years
- □ b. Estrogen Replacement Therapy (ERT) ____ years
- □ c. Tamoxifen ____ years

11.3 I have had an abnormal Test / Procedure / Imaging for? (Check all that apply)

□ a. Breast (s) □ b. Uterus □ c. Ovary (s) □ d. Pap

11.4 I have regular check-ups for the following:

a. Pap	☐ Yes	☐ No
b. Breast	☐ Yes	☐ No
c. Mammogram	☐ Yes	☐ No
d. Self-Breast Exam	☐ Yes	☐ No

11.5 Have you had any of the following cancers? (Check all that apply) If 1-11 months, put 0.

Disease	How many Years?	On Meds?
☐ a. Breast		☐
☐ b. Cervix		☐
☐ c. Uterus		☐
☐ d. Ovary		☐

12. Preventive Maintenance and Health Utilization

12.0 Do you have the following tests annually?

a. Regular Check Up	☐ Yes	☐ No
b. Blood Pressure	☐ Yes	☐ No
c. EKG	☐ Yes	☐ No
d. Blood Chemistry (Full panel)	☐ Yes	☐ No
e. Blood Sugar (Fasting)	☐ Yes	☐ No
f. Lipid Panel (Cholesterol)	☐ Yes	☐ No

12.1 Do you have blood in your stool? ☐ Yes ☐ No

12.2 If you are 50 years or older, have you had a colonoscopy in the past 10 years? ☐ Yes ☐ No

12.3 Do you have a primary care physician? ☐ Yes ☐ No

12.4 If yes, how satisfied with your relationship with your physician? ☐ Good ☐ Fair ☐ Poor

12.5 How many days did you see the doctor in the last 12 months? _____ days

12.6 How many days have you visited the emergency room in the last 12 months? _____ visits

12.7 How many days have you been hospitalized in the last 12 months? _____ days

13. Readiness to Change

13.0 How ready are you to do the following?

□ a. Reduce Alcohol Use	□ Not Ready	□ Considering	□ Ready	□ Doing it	□ N/A
□ b. Practice Disease Management	□ Not Ready	□ Considering	□ Ready	□ Doing it	□ N/A
□ c. Exercise	□ Not Ready	□ Considering	□ Ready	□ Doing it	□ N/A
□ d. Reduce Cholesterol	□ Not Ready	□ Considering	□ Ready	□ Doing it	□ N/A
□ e. Lose Weight	□ Not Ready	□ Considering	□ Ready	□ Doing it	□ N/A
□ f. Stop Smoking	□ Not Ready	□ Considering	□ Ready	□ Doing it	□ N/A
□ g. Reduce Stress	□ Not Ready	□ Considering	□ Ready	□ Doing it	□ N/A
□ h. Start a Coaching Program	□ Not Ready	□ Considering	□ Ready	□ Doing it	□ N/A

14. Interest Survey

14.0 If offered at work, what topics would you like to learn more about? (check all that apply)

□ a. Cancer Risk Reduction
□ b. Cholesterol Reduction
□ c. Coronary Risk Reduction
□ d. CPR / First-Aid
□ e. Diabetic Risk Reduction
□ f. Fitness, Aerobics, Walking
□ g. Injury and Accident Prevention
□ h. Interpersonal Communication
□ i. Men's Health
□ j. Nutrition and Weight Loss
□ k. Smoking Cessation
□ l. Stress Management
□ m. Financial Well-being
□ n. Women's Health

15. Absence and Illnesses

15.0 In the past 12 months, what was the total number of days you missed work due to the following medical reasons? Fill in the number of days below. (Employees Only)

Condition	Too sick to work	Worked while sick
□ a. Allergies	____ days	____ days
□ b. Arthritis	____ days	____ days
□ c. Asthma	____ days	____ days
□ d. Sinus	____ days	____ days
□ e. Diabetes	____ days	____ days
□ f. Chest Cold or Flu	____ days	____ days
□ g. Chronic Pain	____ days	____ days
□ h. Back Problems	____ days	____ days
□ i. Heart Disease	____ days	____ days
□ j. High Blood Pressure	____ days	____ days
□ k. Anxiety / Stress	____ days	____ days
□ l. Depression	____ days	____ days
□ m. Migraine / Chronic Headache	____ days	____ days
□ n. Accident or Injury	____ days	____ days
□ o. Menstrual Cycle	____ days	____ days

15.1 In the past 12 months, what is the total number of days you missed work for any medical reason (physical or psychological)?

□ a. 0 □ b. 1-5 □ c. 6-10 □ d. 11-15 □ e. 16 or more

Thank you for participating!