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Providence Health Assessment for use after 1/1/12 for PEBB

Personal Health Assessment Questionnaire

0	-	-	-	-	1
0	0	0	0	1	0
0	1	1	0	0	1
1	0	1	0	1	0
1	1	0	0	1	0
1	1	1	1	0	1
1	t7jm9IS	1	1	0	0
0	0	1	1	webpra-demo	

The questionnaire below is only a sample for demonstration purposes. Any answers provided will not be processed for the generation of a personal report or HEM compliance.

Email

If possible, please provide an email address. It will be used only for infrequent communication regarding this personal health assessment.

Name

Address

City State Zip

Complete each question as best you can, by indicating the best response. Your participation in this questionnaire is voluntary. However, to receive the most benefit from your report, please answer all questions.

Your results will be kept strictly confidential.

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If you wish to finish this questionnaire later, be sure to still select **[Done & Check]** and click the **[Go]** button at the bottom of this page. Your answers can then be held until your return up to 92 days later.

1 Authorization

Confirmed

2 Gender

Male

Female

3 Age (at last birthday)

years old

4 Are you pregnant?

If Yes,
complete the
questionnaire
based on
your health
condition and
lifestyle
before
pregnancy.

5 Height (without shoes)

feet inches **OR** centimeters

6 Weight (without shoes)

pounds

7 Waist circumference

inches

8 What is your blood pressure now?

Systolic (high number)

Diastolic (low number)

I'm not sure

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9 What is your total cholesterol level? (based on a blood test) mg/dL I'm not sure

10 What is your HDL cholesterol level? (based on a blood test) mg/dL I'm not sure

11 What is your LDL cholesterol level? (based on a blood test) mg/dL I'm not sure

12 What is your triglycerides level? (based on a blood test) mg/dL I'm not sure

13 What is your glucose level? (based on a blood test) mg/dL I'm not sure

Fast (please indicate if blood test was after no food or drink for at least 12 hours)

Health-Related Behaviors

14 **CIGARETTE SMOKING**
How would you describe your cigarette smoking habits?
 Still smoke, **Go to [question 15](#)**
 Used to smoke, **Go to [question 16](#)**
 Never smoked, **Go to [question 17](#)**

15 *Still smoke* cigarettes per day **Go to [question 17](#)**

16 *Used to smoke*
How many years has it been since you smoked cigarettes on a fairly regular basis? years

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	What was the average number of cigarettes per day that you smoked in the 2 years before you quit?	<input type="text" value="-"/>
17	OTHER FORMS OF TOBACCO Do you smoke or use	<input type="text" value="-"/> Pipes <input type="text" value="-"/> Cigars <input type="text" value="-"/> Smokeless tobacco
18	How often do you use drugs or medication (including prescription drugs) which affect your mood or help you to relax?	<input type="text" value="-"/>
19	How many drinks of alcoholic beverages do you have in a typical week? (1 drink = 1 beer, glass of wine, shot of liquor or mixed drink)	<input type="text" value=""/> drinks
20	How many times in the last month did you drive or ride when the driver had perhaps too much to drink?	<input type="text" value=""/> times last month
21	In the next 12 months, how many miles will you probably drive or ride in each of the following? A. Car, truck, van or SUV	<input type="text" value="-"/>
	B. Motorcycle	<input type="text" value="-"/>
22	What percent of the time do you usually buckle your safety belt when driving or riding?	<input type="text" value="-"/>
23	On the average, how close to the speed limit do you usually drive?	<input type="text" value="-"/>
24	On a typical day, how do you usually	<input type="text" value="-"/>

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	travel?	
25	Each day, how many servings of foods do you eat that are high in fiber, such as whole-grain bread, high-fiber cereal, fresh fruits or vegetables? (serving size: 1 slice bread, 1/2 cup or 110 ml vegetables, 1 medium fruit, 3/4 cup or 170 ml cereal)	<input type="text" value="-"/>
26	Each day, how many servings of foods do you eat that are high in cholesterol or fat such as fatty meat, cheese, fried foods or eggs? (serving size: 3 1/2 oz or 100 g meat, 1 egg, 1 oz/slice/28 g cheese)	<input type="text" value="-"/>
27	In the average week, how many times do you engage in physical activity (exercise or work which is hard enough to make you breathe more heavily and to make your heart beat faster) and is done for at least 20 minutes? Examples include running, brisk walking or heavy labor, e.g. chopping, lifting, digging, etc.	<input type="text" value="-"/>
28	How many days per week do you get 30 minutes or more (for at least 10 minutes at a time) of light to moderate physical activity? Examples include walking, mowing (push mower), slow cycling.	<input type="text" value="-"/>
Quality-of-Life Indicators		
29	Considering your age, how would you describe your overall physical health?	<input type="text" value="-"/>
30	How many hours of sleep do you usually get at night?	<input type="text" value="-"/>
31	In general, how satisfied are you with your life?	<input type="text" value="-"/>

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(include personal and professional aspects)

32 In general, how strong are your social ties with your family and/or friends?	-
33 Have you suffered a personal loss or misfortune in the past year? (for example: a job loss, disability, divorce, separation, jail term, or the death of someone close to you)	-
34 How often do you feel tense, anxious, or depressed?	-
35 During the past year, how much effect has stress had on your health?	-

Medical History and Self-Care

36 Do you have:			
Allergies	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Arthritis	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Asthma	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Back pain	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Cancer	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care

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Chronic bronchitis/emphysema	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Chronic pain	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Depression	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Diabetes	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Heart problems	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Heartburn or acid reflux	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
High blood pressure	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
High cholesterol	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Menopause (<i>women only</i>)	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Migraine headaches	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Osteoporosis	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care

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Sleep disorder	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Stroke	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Thyroid disease	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care
Other condition	-	<input type="checkbox"/> Taking medication	<input type="checkbox"/> Under medical care

37

When was the last time you had these preventive services or health screenings?

-	Colon cancer screen
-	Rectal exam
-	Flu shot
-	Tetanus shot
-	Blood pressure check
-	Cholesterol check
-	Dental exam

for women only

-	Pap test
-	Mammogram
-	Breast exam by a physician or nurse

for men only

-	Prostate exam
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38

In the past 12 months, how many times have you:

-	Visited a physician's office or clinic
-	Gone to the emergency room

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	<input type="text" value="-"/>	Stayed overnight in a hospital
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Women (Men Go To [Question 43](#))

39	Have you had a hysterectomy operation?	<input type="text" value="-"/>
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40	At what age did you have your first menstrual period?	<input type="text" value="-"/>
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41	How old were you when your first child was born?	<input type="text" value="-"/>
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42	How often do you examine your breasts for lumps?	<input type="text" value="-"/>
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Men (Women Go To [Question 44](#))

43	How often do you examine your testicles for lumps?	<input type="text" value="-"/>
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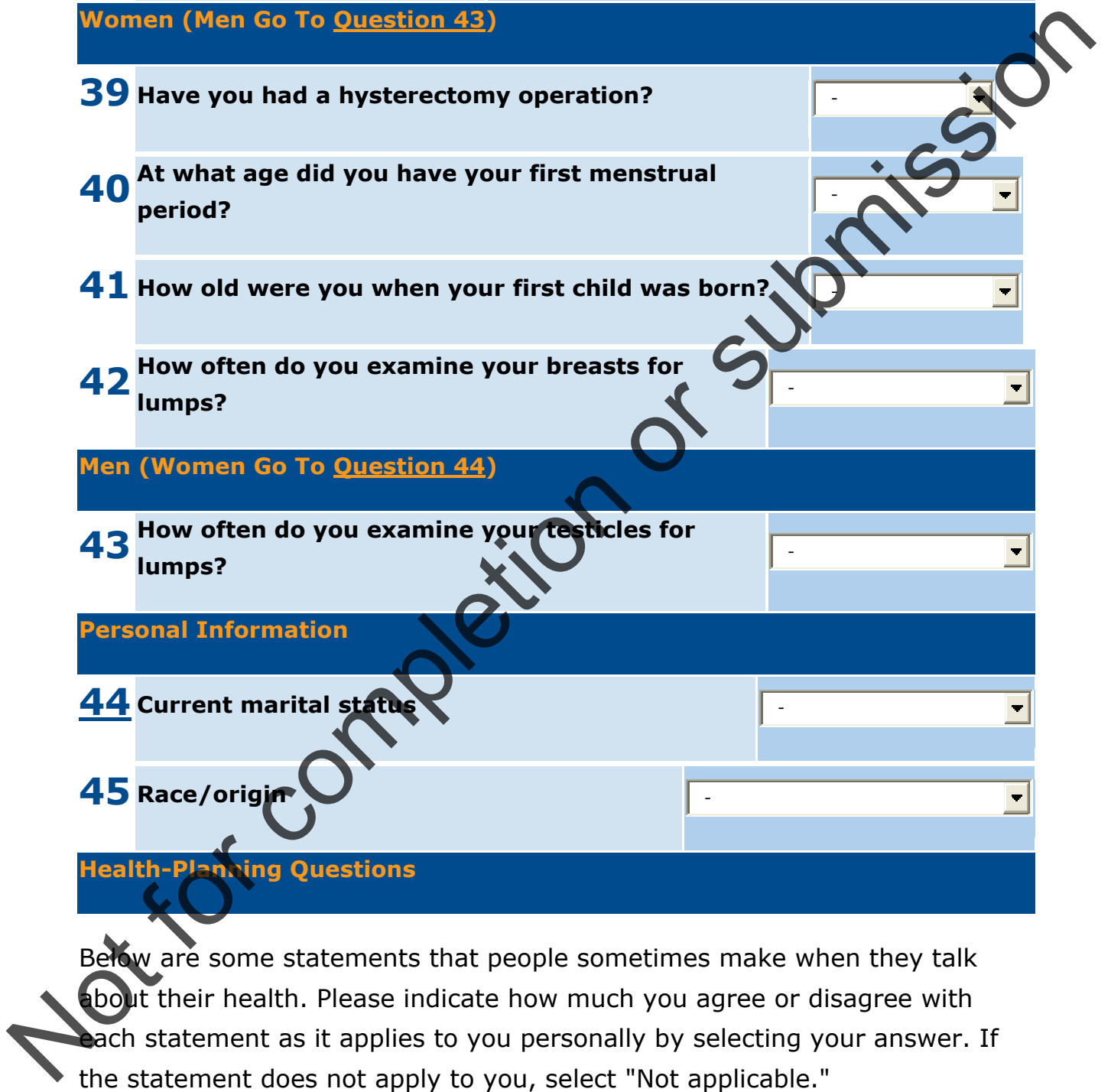
Personal Information

44	Current marital status	<input type="text" value="-"/>
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45	Race/origin	<input type="text" value="-"/>
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Health-Planning Questions

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by selecting your answer. If the statement does not apply to you, select "Not applicable."



46 When all is said and done, I am the person who is responsible for taking care of my health.

47 Taking an active role in my own health care is the most important thing that affects my health.

48 I know what each of my prescribed medications do.

49 I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.

50 I am confident that I can tell a doctor concerns I have even when he or she does not ask.

51 I am confident that I can follow through on medical treatments I may need to do at home.

52 I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising.

53 I know how to prevent problems with my health.

54 I am confident I can figure out solutions when new problems arise with my health.

55 I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.

56 In the next 6 months, are you planning to make any changes to keep yourself healthy or improve your health?

Increase physical activity

Lose weight

Reduce alcohol use

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-	Quit or cut down smoking
-	Reduce fat/cholesterol intake
-	Lower blood pressure
-	Lower cholesterol level
-	Cope better with stress

Currently Employed Only

57 In the past year, how many days of work have you missed due to personal illness?

-

58 Would you agree you are satisfied with your job?

-

59 During the past 4 weeks, how much did problems with your health affect your productivity while you were working?

-

60 How many hours did you take off from work over the past 2 weeks to take care of sick children, adults or elders? (This might include taking children to doctor appointments, staying home with a sick child or parent, or calling doctors or health insurance companies.)

-	Child
-	Adult
-	Elder

61 Please think of your work experiences over the past 4 weeks (28 days). In the spaces provided below, enter the number of days you spent in each of the following work situations.
In the past 4 weeks (28 days), how many days did you ...

a. Miss an entire work day because of problems with your physical or mental health? (Please include only days)

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days missed for your <u>own</u> health, not someone else's health.)	
b. Miss an <u>entire</u> work day for any other reason (including vacation)?	<input type="text"/> days
c. Miss <u>part</u> of a work day because of problems with your physical or mental health? (Please include only days missed for your <u>own</u> health, not someone else's health.)	<input type="text"/> days
d. Miss <u>part</u> of a work day for any other reason (including vacation)?	<input type="text"/> days
e. Come in early, go home late, or work on your day off?	<input type="text"/> days

Thank you for participating in this personal health assessment.

If you are living with or are at high risk of developing a serious or life-threatening illness, you may be eligible for special resources offered by Providence Health & Services/Providence Health Plan that help you get the care you need.

By answering "Yes" in the box below, you allow your personal health assessment to be reviewed by a registered nurse at Providence Health Plan or your provider. A Providence representative may contact you if your responses indicate you may benefit from one of our care management or health coaching programs. The Providence representative can provide information and help you with coordination of care.

Please note that the personal health assessment is intended to help you achieve your health goals. Providence Health Plan does not use personal

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health assessment data to calculate health insurance premiums or to determine eligibility for coverage.

If you change your mind later about whether to allow Providence Health & Services/Providence Health Plan to review your personal health assessment, please write to us at P.O. Box 4327, Portland OR 97208-4327.

62 **Yes**, please review my personal health assessment to determine if I am eligible for special assistance; **or**
No, please do not review my personal health assessment or contact me about the results.

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