December 9, 2008

SAMPLE

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Health Assessment

Whether you think you're perfectly healthy or know you have a few areas you can work on, taking MyHealth Assessment may be the smartest thing you can do for your health.

Your privacy in taking this assessment is something we take very seriously. Please see our privacy policy for details on how we protect you.

Please complete each page of the Health Assessment in its entirety and click "Submit" to avoid losing any of the data you have entered.

About You: Enter your personal information below.

What is your height?
5' 7"

What is your weight without clothes and pre-pregnancy?
145 lbs

What is your waist measurement?
28 inches (Measure approximately 2 inches below your belly button.)

What is your ethnic origin? (Optional)

- ○ Asian
- ○ Black or African-American
- ○ Hispanic or Latino
- ○ Indian
- ○ Native American, Eskimo or Inuit
- ○ Native Hawaiian or other Pacific Islander
- ◉ White/Caucasian
- ○ Multi-ethnic
- ○ Other

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- ○ Unknown

What is the highest level of education you have completed?

- ○ Grade school or less
- ○ Some high school
- ○ High school graduate
- ○ Some college or vocational school
- ◉ College graduate
- ○ Post-graduate or professional school

Enter the most recent values for the following tests and indicate the approximate date for each reading.

	I don't know	Test result	Test date
Systolic blood pressure (upper number)	☑		
Diastolic blood pressure (lower number)	☑		
Normal resting pulse rate	☑		
% body fat	☑		
Total cholesterol (mg/dl)	☑		
LDL (bad) cholesterol (mg/dl)	☑		
HDL (good) cholesterol (mg/dl)	☑		
Triglyceride level (mg/dl)	☑		
Blood sugar (glucose) level (mg/dl)	☑		

What type of blood sugar (or glucose) measurement was your most recent reading?

- ○ Non-Fasting

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- ○ Fasting
- ◉ Unknown

What have you been *told* about your blood pressure?

- ○ My blood pressure has been high (over 140/90).
- ○ My blood pressure has been moderately high (between 120/80 and 140/90).
- ◉ My blood pressure is normal (below 120/80).
- ○ I don't know.

What have you been *told* about your cholesterol ?

- ○ My cholesterol has been high (total cholesterol over 240 and/or LDL over 160).
- ○ My cholesterol has been moderately high (total cholesterol between 200 and 240 and/or LDL between 130 and 160).
- ◉ My cholesterol is normal (total cholesterol below 200 and LDL below 130).
- ○ I don't know.

Has a doctor ever diagnosed you with any of the following?

	No	Yes
Allergies	◉	○
Arthritis	◉	○
Asthma	◉	○
Cancer (Breast)	◉	○
Cancer (Cervical)	◉	○
Cancer (Colon)	◉	○
Cancer (Lung)	◉	○
Cancer (Other, not listed)	◉	○
Chronic back pain or sciatica	◉	○
Chronic neck pain	◉	○
Colon polyps	◉	○
Congestive heart failure	◉	○
COPD or Emphysema	◉	○

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Depression	●	○
Diabetes Type 1	●	○
Diabetes Type 2	●	○
GERD (Gastro-Esophageal Reflux Disease or Chronic Heartburn)	●	○
Heart attack	●	○
Heart arrhythmia or irregular heartbeat	●	○
Heart disease or angina (heart-related chest pain)	●	○
Menopause	○	●
Migraines	○	●
Osteoporosis	○	●
Stroke	●	○

submit

progress 11%

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You still have unanswered questions or invalid answers. Please complete all questions, then click '**submit**' to continue. Questions needing your attention are marked.

Existing Conditions: On the previous page, you indicated having been diagnosed with the condition(s) below. Where possible, answer the following questions to provide more specific details.

Please indicate whether you currently have symptoms and/or are being treated for these conditions.

	I currently have symptoms	I am currently being treated
Menopause	☐	☐
Migraines	☑	☐
Osteoporosis	☐	☑

Select the approximate date(s) you were first diagnosed with these conditions. If the exact dates are not available, enter as much information as you know or leave them blank.

Menopause

Migraines

Osteoporosis

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Preventive Screenings and Exams: Estimate when the following preventive screenings or exams have been performed. (Some may not apply to you.)

When did you last have the following health tests or procedures?

	In the past year	In the past two years	In the past three years	In the past five years	Over five years ago	Never	Does not apply
Colonoscopy	○	●	○	○	○	○	○
Dental exam	●	○	○	○	○	○	○
Digital rectal exam	○	○	●	○	○	○	○
Flu vaccine	○	○	●	○	○	○	○
Glaucoma screening	○	●	○	○	○	○	○
Physical exam	○	●	○	○	○	○	○
Stool blood test	○	○	○	○	○	○	○
Vision exam	○	○	●	○	○	○	○

Women's Health

	In the past year	In the past two years	In the past three years	In the past five years	Over five years ago	Never	Does not apply
Breast exam by health care professional	●	○	○	○	○	○	○
Cervical cancer screening (Pap smear)	○	●	○	○	○	○	○
Mammogram	○	●	○	○	○	○	○

SAMPLE

Do you do a monthly breast self-exam?

- (•) Yes
- ( ) No

Have you given birth to a child who weighed 9 lbs or more?

- ( ) Yes
- (•) No

submit

progress 35%

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Health Assessment

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Approximate Date for Screenings and Exams: On the previous page, you indicated that you had the following screenings and exams within the past five years. Provide more specific dates below.

Select the approximate date(s) of your screenings or exams. If the exact dates are not available, enter as much information as you know or leave them blank.

Screening or Exam	Month/Day (optional)/Year
Colonoscopy	
Dental exam	
Digital rectal exam	
Flu vaccine	
Glaucoma screening	
Physical exam	
Stool blood test	
Vision exam	
Breast exam by health care professional	

SAMPLE

Cervical cancer screening (Pap smear)			
Mammogram			

Family History: Indicate whether you have a family history of the following conditions. A family history of some conditions may indicate an increased likelihood for developing that condition.

Has a biological parent, brother, or sister had any of the following?

	Yes	No	Not sure
Asthma	○	○	○
Breast cancer	○	○	○
Colon cancer	○	○	○
Colon polyps	○	○	○
Depression	○	○	○
Diabetes	○	○	○
Diabetes type 1	○	○	○
Diabetes type 2	○	○	○
Heart attack, angina or heart disease before age 55	○	○	○
High blood pressure	○	○	○
High cholesterol	○	○	○
Stroke	○	○	○

Nutrition: Tell us about your diet. A healthy diet will decrease your likelihood for developing certain conditions.

On average, how many servings of the following foods do you eat per day?

Fruits or vegetables (3/4 cup of 100% fruit juice; 1 medium piece of fruit; 1/2 cup chopped, cooked, raw, or canned vegetables; or 1 cup raw, leafy vegetables)

_____ *Per day*

SAMPLE

Whole-grain foods (1 slice whole-wheat bread, 1 cup oatmeal, 1/2 cup cooked brown rice, or 3 cups popped popcorn)

_____ *Per day*

Low-fat dairy products (1 cup milk or yogurt; 1 to 1.5 ounces cheese)

_____ *Per day*

High-quality proteins (2 to 3 ounces of lean meat, poultry, tofu or fish; 1 cup of cooked dry beans, nuts, or seeds; 2 eggs; or 4 tablespoons of peanut butter)

_____ *Per day*

High-fat foods (whole milk, butter, cheese, fatty meats, saturated and trans fats in chips and fried foods)

_____ *Per day*

Tobacco and Alcohol Use: Answer the following questions about your use of tobacco and alcohol. Tobacco and excessive alcohol use may increase the likelihood for developing certain conditions.

Indicate your tobacco use history for the following:

	Never Used	Currently Use	Previously Used
Cigarettes	○	○	○
Chewing or smokeless tobacco	○	○	○
Cigars	○	○	○
Pipes	○	○	○

Are you exposed to secondhand tobacco smoke more than once a week for 30 minutes or longer?

○ Yes
○ No

On an average day, how many alcoholic drinks do you usually consume? One drink equals one bottle of beer or wine cooler (12 ounces), one glass of wine (5 ounces), or one shot of 80-proof distilled spirits (1.5 ounces).

○ 0
○ 1
○ 2
○ >2

SAMPLE

Have you had 5 or more alcoholic drinks in a single sitting in the last 6 months?

- Yes
- No

How many times in the last 6 months did you drive when you had too much to drink?

How many times in the last 6 months did you ride with someone who had too much alcohol to drink?

submit

progress **57%**

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Health Assessment

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Please complete each page of the Health Assessment in its entirety and click "Submit" to avoid losing any of the data you have entered.

Healthy Changes: Are you ready to make changes in your life?

Indicate your level of commitment or interest in each of the healthy changes below.

	I have no need to.	I have no plans to.	I plan to within the next 6 months.	I plan to within the next month.	I have been less than 6 months.	I have been more than 6 months.
Improve my diet	○	○	○	○	○	○
Get current with my preventive screenings or exams	○	○	○	○	○	○
Start or continue a stress reduction program	○	○	○	○	○	○

SAMPLE

Eliminate drug use	○	○	○	○	○	○

Work Performance: Has your health affected your work performance?

During the last month, what percentage of your work performance was affected by an underlying health condition, including allergies, headaches, back pain, depression, arthritis, or any other health condition?

(0-100)

Overall Health: How is your overall health?

Over the past 6 months, how would you describe your overall health compared to others your age?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

Do you have any difficulty with the activities of daily living? (such as eating, bathing, dressing, or using the bathroom)

	No	Yes
Bathing/Showering	○	○
Bowel or bladder control	○	○
Dressing	○	○
Eating	○	○
Getting Around	○	○
Personal device care (hearing aids, glasses, prosthetics, adaptive equipment, etc.)	○	○
Personal hygiene/grooming	○	○
Sexual activity	○	○
Sleep/Rest	○	○

SAMPLE

Toilet Hygiene

Medical Care: How often have you received medical care?

In the past year (excluding pregnancy), approximately how many times have you:

Been to the doctor or clinic?
_____ times
Been hospitalized overnight?
_____ days
Been to the emergency room?
_____ times
Missed work due to illness or injury?
_____ days
Filled or refilled a prescription?
_____ times

Self-Care: Do you use self-care resources?

How many times in the past year have you used a self-care resource, including books, articles, a handbook, a website, or any other such resource?
_____ times

In the past 2 weeks, how much of the time did your physical health or emotional problems make it difficult for you to do the following?

	Difficult all of the time (100%)	Difficult most of the time	Difficult some of the time (about 50%)	Difficult a slight bit of the time	Difficult none of the time (0%)	Does not apply to my job
get going easily at the beginning of the workday						
start on your job as soon as you arrived at work						

SAMPLE

In the past 2 weeks, how much of the time were you able to sit, stand, or stay in one position for longer than 15 minutes while working, without difficulty caused by physical health or emotional problems?

Able all of the time (100%)	Able most of the time	Able some of the time (about 50%)	Able a slight bit of the time	Able none of the time (0%)	Does not apply to my job
○	○	○	○	○	○

In the past 2 weeks, how much of the time were you able to repeat the same motions over and over again while working, without difficulty caused by physical health or emotional problems?

Able all of the time (100%)	Able most of the time	Able some of the time (about 50%)	Able a slight bit of the time	Able none of the time (0%)	Does not apply to my job
○	○	○	○	○	○

In the past 2 weeks, how much of the time did your physical health or emotional problems make it difficult for you to concentrate on your work?

Difficult all of the time (100%)	Difficult most of the time	Difficult some of the time (about 50%)	Difficult a slight bit of the time	Difficult none of the time (0%)	Does not apply to my job
○	○	○	○	○	○

In the past 2 weeks, how much of the time did your physical health or emotional problems make it difficult for you to speak with people in-person, in meetings or on the phone?

Difficult all of the time (100%)	Difficult most of the time	Difficult some of the time (about 50%)	Difficult a slight bit of the time	Difficult none of the time (0%)	Does not apply to my job
○	○	○	○	○	○

In the past 2 weeks, how much of the time did your physical

SAMPLE

health or emotional problems make it difficult for you to do the following?

	Difficult all of the time (100%)	Difficult most of the time	Difficult some of the time (about 50%)	Difficult a slight bit of the time	Difficult none of the time (0%)	Does not apply to my job
handle the workload	○	○	○	○	○	○
finish the work on time	○	○	○	○	○	○

Feedback: Please answer the questions below. They will help us improve this health risk assessment.

How strongly do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
This questionnaire was simple to complete.	○	○	○	○	○
This questionnaire was easy to understand.	○	○	○	○	○
This questionnaire helped me think about my health.	○	○	○	○	○

Approximately how long did it take you to fill out this questionnaire?

minutes

Your health plan may offer programs to help manage health risks identified in this assessment. If you qualify, would you like to be contacted about these programs?

◉ Yes

○ No

You're nearly done. After you click **'submit'** below you'll see what all of this means for you.

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Click Here for Healthy Lifestyles

Health Assessment

Now that you have your **MyHealth Assessment score**, you can see how it compares to your peers.

If you had taken the previous assessment and this is your first time finishing the new MyHealth Assessment, your previous assessment score has been converted to a **100-point scale** and is listed below your new score for comparison. Also, your **previously identified risks** are shown where applicable on the new **MyHealth Assessment report pages**. If your score could use some improvement, explore the fun, **interactive tools** below to see what actions will have the most impact on raising your score and improving your health.

To print a **confirmation** of your health score, click here.

- **Take MyHA Now**
- **MyHA Summary**
- **Risk Reports**
- **Condition Reports**
- **Physician Summary**
- **Health Care Costs**

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Your MyHA Score

66

out of 100
previous score:

Martha, based upon your answers, your calculated MyHA score is 66, compared to your peer avera
80. Click the check boxes below or use the **'Improve Your Score'** sliders to see how simply impro
stress can impact your overall score, as well as your risk of developing certain health conditions.

- [ ] Decrease your stress.
- [ ] Stop abusing prescription or recreational drugs.
- [ ] Eat a healthier diet.

Improve Your Score

How does this tool work?

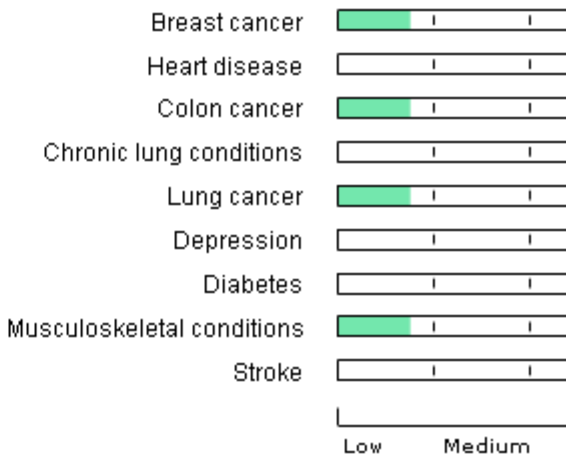
Below are some of your key modifiable risk factors. Use the sliders to see how changing your behavior can change your risks of certain conditions.

The changes you make to the risk factors the left will affect your risk of these condi

Highest Risk | Medium Risk | Lowest Risk

Stress	Substance Use	Nutrition	Blood Sugar
High Risk	High Risk	High Risk	High Risk
Low Risk	Low Risk	Low Risk	Low Risk

Reset to your current values RESET



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 Take the next step with your Stress Risk Report

 Visit the Lifestyle Centers

Other Resources

- Symptom Checker
- Women's Health Center