

“A WINNING HAND FOR WOMEN’S HEALTH”

Health Assessment - POST

The information in this questionnaire and the results of your health screening are confidential

Name: _____

Today’s Date: _____

_____ Address _____ City _____ State _____ Zip _____ Social Security
Number _____

Date of Birth: _____ (_____) _____
Month Day Year Telephone Number

1. Have you ever been told that you have high blood pressure? _____ Yes _____ No
If “Yes”, do you check it every day? _____ Hardly ever _____ Occasionally _____ Sometimes
_____ Frequently _____ Almost always
2. Do you smoke or use any other tobacco products? _____ Yes _____ No
3. When was your last mammogram? _____ 1 yr. or less _____ 2-3 yrs. _____ 5 yrs. or more _____
never
4. Do you examine your breasts every month for lumps? _____ Hardly ever _____ Occasionally
_____ Sometimes _____ Frequently _____ Almost always
5. How long has it been since you had a pap smear for cancer? _____ years
6. Has any member of your immediate family had cancer? _____ Yes _____ No
If “Yes”, which family member(s)?

If “Yes”, what type of cancer(s)?

7. Are you currently taking hormones? _____ Yes _____ No
8. Have you ever been told that you have high blood sugar or diabetes? _____ Yes _____ No
If “Yes”, do you take your blood sugar reading every day? _____ Hardly ever _____ Occasionally
_____ Sometimes _____ Frequently _____ Almost always
9. Do you read food labels? _____ Hardly ever _____ Occasionally _____ Sometimes
_____ Frequently _____ Almost always
10. In an average day, how often do you eat the following foods? (Please write the numbers.)
_____ High-fiber foods (whole-grain breads and cereals, legumes)
_____ Fruits and vegetables
_____ Foods high in calcium (milk, yogurt, cheese)
11. In an average day, how often do you eat the following foods?

♣ Sugar (sodas, cake, cookies, candy, etc.)

♦ Fat (chips, french fries, fried foods, etc.)

♥ Sodium (salt, pickles, ham, etc.)

♣ _____ Hardly ever _____ Occasionally _____
Sometimes

_____ Frequently _____ Almost every day

♦ _____ Hardly ever _____ Occasionally _____
Sometimes

_____ Frequently _____ Almost every day

♥ _____ Hardly ever _____ Occasionally _____
Sometimes

_____ Frequently _____ Almost every day

12. Have you ever been told that you have osteoporosis (thinning bones)? _____ Yes _____ No
13. Do you take calcium supplements? _____ Hardly ever _____ Occasionally _____ Sometimes
_____ Frequently _____ Almost every day
14. In general, how satisfied are you with your life? (Please ✓ the one that best describes you.)
_____ Mostly satisfied
_____ Partly satisfied
_____ Not satisfied
15. How would you rate your stress level? (Please ✓ the one that best describes you.)
_____ High
_____ Average
_____ Low
16. Do you now exercise (brisk walking, jogging, swimming, biking) at least 3 times a week for at least 20 minutes? (Place a ✓ beside the sentence that best describes what you do now.)
_____ Yes, I have been exercising for more than 6 months
_____ Yes, I have been exercising for less than 6 months
_____ No, but I am planning to start exercising in the next 30 days
_____ No, but I am planning to start exercising in the next 6 months
_____ No, and I don't plan to start in the next 6 months
17. How many hours daily do you spend watching television or in other sedentary activities? _____ hours
18. How many hours of sleep do you average each night? _____ hours

