TACT

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Health Risk Assessment

Thank you for taking the time to answer this health risk assessment, which will be used to determine your current individual health status. Please fully answer each of the following questions.

Personal Information: *Please print*

First Name: ______________________________ Last Name: ______________________________

Date of Birth: ______ /______ /______ Phone: (______) ______ - ____________

Current Mailing Address: ____

City: ____________________________________ State: __________ Zip Code: __________

Current Employer: ____

Gender: ☐ Male ☐ Female Age: __________ Marital Status______________

Current Height: Feet ______ Inches______ Current Weight: Pounds ______

B/P: __________________ Pulse:__________________

03/09

HEALTH QUESTIONS

1. GENERAL HEALTH

Complete the following statement. In general, I feel my overall health is:

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

2. FAMILY HISTORY

Mark any of the following health problems found in your family *(mother, father, brother, sister)*.

- ☐ Colorectal Cancer
- ☐ Breast Cancer
- ☐ Diabetes
- ☐ Coronary Heart disease, heart attack, or coronary surgery before age 55 for men, before age
- ☐ 65 for women
- ☐ High blood pressure
- ☐ High blood cholesterol
- ☐ Other
- ☐ None

3.PERSONAL HEALTH HISTORY

Has a doctor informed you that you currently have any of the following health problems? If yes, please write in the medication you are taking in the blanks provided.

- ☐ Asthma ______________________
- ☐ Bowel polyps or bowel disease ______________________
- ☐ Cancer other than skin cancer ______________________
- ☐ Chronic bronchitis or emphysema ______________________
- ☐ Coronary heart disease, congestive heart failure, angina, heart attack or heart surgery ______________________
- ☐ Diabetes ______________________
- ☐ High blood pressure ______________________
- ☐ High cholesterol ______________________
- ☐ Chronic back pain ______________________
- ☐ Stroke or restricted blood flow to head or legs ______________________
- ☐ Surgery in the past 5 years ______________________
- ☐ None

HEALTH QUESTIONS

4. CURRENT SYMPTOMS

Mark any of the following symptoms you have experienced within the last four weeks.

- ☐ Chest pain or discomfort, frequent palpitations or fluttering in the heart
- ☐ Unusual shortness of breath
- ☐ Unexplained dizziness or fainting
- ☐ Frequent heart palpitation or fluttering
- ☐ Temporary numbness or tingling, blurred vision, or lightheadedness
- ☐ Frequent urination or unusual thirst
- ☐ Frequent back pain
- ☐ Trouble sleeping at night
- ☐ Joint pain or swelling
- ☐ None

5. BODILY PAIN

How much bodily pain have you had during the last four weeks?

- ☐ None
- ☐ Very mild
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Very severe

6. HEALTH LIMITATIONS

During the last four week, how much difficulty did you have doing your work or other regular daily activities as a result of your physical health?

- ☐ None
- ☐ A little bit
- ☐ Some
- ☐ Quite a bit
- ☐ Could not do daily work

7. SMOKING STATUS

Mark the appropriate response.

- ☐ Have never smoked
- ☐ Quit smoking two or more years ago
- ☐ Quit smoking less than two years ago
- ☐ Smoke pipe or cigar only
- ☐ Currently smoke less than 10 cigarettes per day
- ☐ Currently smoke ten or more cigarettes per day
- ☐ Currently use smokeless tobacco

HEALTH QUESTIONS

8. NUMBER OF DRINKS

How many alcoholic drinks do you usually have per week?

One drink is a 12oz beer, 5oz of wine or 1.5 oz of liquor

- ☐ Seldom or never
- ☐ One to seven
- ☐ Eight to fourteen
- ☐ Fifteen to twenty
- ☐ Twenty-one or more

9. EXERCISING

How many days per week do you engage in exercises of at least 20-30 minutes duration other than work?

- ☐ None
- ☐ 1-2 times per week
- ☐ 3-4 times per week
- ☐ 5 or more times per week

10. DIET

Indicate the kinds of food you eat most often.

- ☐ High fat content — Hamburgers, fries, steaks, cheeses, sweets, whole milk, cakes, candy, fried foods, and fast foods.
- ☐ Low fat content — Lean meats, poultry, fish, skim milk, low fat dairy products, fruits, vegetables whole grains, and salads.

11. STRESS

Overall, how often would you say that you experience stress in your life?

- ☐ Every day
- ☐ On a regular basis
- ☐ Occasionally
- ☐ Rarely or never

I give my permission to be contacted by mail or phone to discuss the results of this appraisal with a qualified healthcare professional. ☐ Yes ☐ No

Signature:____ Date: _____/_____/_____