Personal Health Assessment

Please mark the most appropriate response

	Excellent	Very Good	Good	Fair	Poor
In general , I consider my health to be	○	○	○	○	○
My weekly physical activity routine is	○	○	○	○	○
I would describe my physical shape (body composition) as	○	○	○	○	○
I would consider the health of the TSU community to be	○	○	○	○	○
I would consider my level of happiness to be	○	○	○	○	○
I would consider my level of stress to be	○	○	○	○	○
I would rate my overall well-being as	○	○	○	○	○
I would consider my eating habits to be	○	○	○	○	○

Do you currently have any kind of health care coverage, including health insurance, HMO's, Medicaid?

- ○ Yes
- ○ No

If Yes, please specify: (select all that apply)

- Dental (Delta Dental, etc.)
- Vision
- Medicaid (Tenn-Care)
- Medicare
- Private (BC/BS, Cigna, etc.)
- Federal (Health-care Exchange Plan)
- Other (please specify):

If you have active insurance coverage, what is your relationship to the current cardholder?

○

I am the active cardholder (Independent)

I am the spouse to the cardholder(dependent)

I am the child of the cardholder (dependent)

I do not have active insurance

Was there a time in the past 12 months when you needed to see a doctor but could not because of cost, distance, fear, or other reasons?

yes

No

If Yes, please specify: (select all that apply):

Cost
Distance
Fear
Lack of transportation
Other (please specify)

Do you have one person you think of as your health-care provider or medical home?

yes

No

When was the last time you has a routine appointment with your health care provider?

Less than 1 month ago

Less than 6 months but more than 1 month ago

Less than 1 year but more than 6 months

More than 1 year ago

I do not have a health-care provider or medical home

Have you EVER had your blood cholesterol checked?

Yes

No

If Yes, what were you told about your blood cholesterol results?

Normal

High

Low

I don't know

How long ago was your blood cholesterol checked?

Less than a year ago

More than a year ago

I have never had it checked

Have you EVER has your blood pressure checked?

Yes

No

If Yes, What were you told about your blood cholesterol results?

Normal

High

Low

I dont know

How long ago was your blood pressure checked?

Less than a year ago

More than a year ago

I have never had it checked

Have you EVER has a test for high blood sugar or diabetes within the past three years?

No

Yes

If Yes, what were the you told about your blood glucose results?

Normal

High

Low

I dont know

How long ago was your blood sugar or diabetes test ?

Less than a year ago

More than a year ago

I have never been tested for blood sugar or diabetes

Have you EVER been told by a doctor, nurse, or other health professional that you are pre-diabetic or borderline diabetic?

No

Yes

If Yes, please specify:

Type 1-Insulin Dependent

Type 2- Non- Insulin Dependent

Do you receive annual physical exams?

Yes

No

How long ago did you last have a full physical exam by a medical provider?

Less than a year ago

More than a year ago, but less than 3 years ago

More than 3 years ago, but less than 5 years

More than 5 years ago

Have you EVER been told by a medical provider that you have any of the following chronic illnesses?

Diabetes

Human Papilloma Virus (HPV or genital warts)

Cancer (any kind)

Asthma

Mental health illness

Obesity

Auto-Immune Disease (lupus, MS, Arthritis, etc.) Please Specify:_____

Other chronic disease Please Specify:_____

Have you EVER been tested for Human Immunosuppressive Virus (HIV)?

Yes

No

Are you immunized against the Human Papilloma Virus (HPV) VACCINE

Yes

No

If Yes, how many shots have you received of the vaccine?

1 shot

2 shots

3 shots

4 shots

Not sure

How long ago did you received the HPV shot?

Less than year ago

More than a year ago

Not sure how long ago

I have not received the vaccine

Are you taking Any medications prescribed by your healthcare provider on a daily basis?

Yes

No

During the past 12 months, have you had an episode of asthma or an asthma attack?

No

Yes

Has your doctor ever told you that you have asthma?

No

Yes

Do you cough when you have a cold?

Yes

No

Do you cough even without a cold?

Yes

No

Do you wheeze or hear a whistling sound when you breathe?

- No
- Yes

If yes, how often do you hear wheezing sounds?

- Daily
- Weekly
- A couple times a month
- A couple times a year
- I don't wheeze

Do you take medicine for wheezing?

- No
- Yes

If yes, how do you treat your wheezing?

- I use medication when I am having an asthma attach only
- I use medication to prevent attacks only
- I use medication for both treating an attack and prevention of future attacks
- I don't take medicine for wheezing

Do you ever get asthma attacks when you participate in rigorous activities (exercising, sport activities, etc.)?

- Yes
- No
- I do not have asthma

In the past 12 months, have you been seen in a Hospital Emergency Room for any health concern?

- No
- Yes

If you have been seen in the ER in the past 12 months was it because you did not have medical coverage to go to a doctor?

- No
- Yes

How much sleep do you get on average each night

- 3 hours or less
- 4-6 hours
- 7-9 hours
- 10-12 hours
- more than 12 hours each night

Diet and Nutrition

During the past week have you participated at least once in any physical activities such as running, calisthenics, golf, gardening, or walking for exercises?

- No
- Yes

In a usual week, do you participate in moderate activities for at least 10 minutes at a time, when you are not working (i.e., brisk, walking, bicycling, vacuuming, etc.)

- No
- Yes

If Yes, what activity do you engage in regularly?

- Walking
- Running
- Exercise Machines (biking, elliptical, etc.)
- Other (please specify):_____

Would you consider yourself to be in your best possible shape?

- No
- Yes

Have your eating habits changed since you have come to Tennessee State University?

- No
- Yes

If yes, please specify your changed habits

- Eating habits improved
- Eating habits worsened

Do you take vitamins or dietary supplements?

- No
- Yes

If yes, how often do you take them?

- Daily
- Weekly
- Bi-weekly
- Occasionally

How would you describe your eating habits?

- Excellent
- Good
- Fair
- Poor
- Very Poor

During High School, did you eat family meals? (A family meal is when all present family members sit down together to eat)

- No
- Yes

Awareness

Have you EVER been abused before?

- Yes
- No

If yes, please specify: (select all that apply):

Emotional
Physical
Sexual
All of the above
Other: (please specify):_____

Have you ever been in an abusive relationship?

Yes

No

If yes, please specify: (select all that apply):

Emotional
Physical
Sexual
All of the above
Other: (please specify):_____

Have you <u>EVER</u> used street drugs? (Street drugs are drugs not prescribed by a licensed medical provider)

Yes

No

On average, how often do you use street drugs?

Less than 3 times a week

3-7 times a week

More than 10 times a week

I don't use street drugs

Do you drink alcoholic beverages?

Yes

No

On average how often do you use drink alcoholic beverages? (Beer, wine, malt beverage, liquor)

Less than 3 time a week

3-7 times a week

More than 10 times a week

I don't drink alcohol

Have you EVER used prescription drugs for pain, anxiety, or sleep?

No

Yes

On average, how often do you use prescription drugs?

Less than 3 times a week

3-7 times a week

More than 10 times a week

I don't use prescription drugs

Do you smoke cigarettes, or cigars?

Yes

No

On average how often do you smoke cigarettes, or cigars

Less than 3 times a day

3-7 times a day

More than 10 times a day

I don't smoke cigarettes

Do you <u>ALWAYS</u> protect yourself by using contraceptive methods when engaging in sexual activity?

Yes

No

I am not sexually active

If Yes, please specify: (select all that apply):

Male/Female condoms
Birth control: Pill, shots (Depo), Spermicide, Implant(s)-(Nexplanon)
Withdrawl
Diaphragm/Cervical Sponge
Internal Devices such as NuvaRing and Morena
Fertility Awareness such as Calendar and Cycle BEADS
Other: (please specify):_____

Do you smoke Marijuana?

Yes

No

On average how often do you smoke Marijuana?

Less than 3 times a day

3-7 times a day

More than 10 times a day

I don't smoke Marijuana

Within the LAST YEAR would you consider yourself to be depressed, overwhelmed, sad, exhausted, or considered suicide?

No

Yes

If Yes, please specify: *(select all that apply)*

Depressed
Sad
Exhausted
Overwhelmed
Suicidal
All of the above
Other (please specify):_____

Within the past 30 days, have you felt sad, blue, depressed?

No

Yes

If Yes, please specify: (select all that apply):

Depressed
Sad
Exhausted
Overwhelmed
All of the above
Other (please specify):_____

Do you increasingly and repeatedly find yourself requesting special considerations to complete your studies? Or in your personal life?

No

Yes

Are you aware of all the vaccinations that are required or strongly recommended for college aged students?

No

Yes

Did you take a nutrition or health education class during high school?

No

Yes

Do you know your sickle cell status?

Do not know

I have sickle cell trait

I have sickle cell disease

I do not have either

Please record the number of times you have consumed the following food item within the LAST WEEK:

Milk	0
Fish (cooked)	0
Cold cereal (with/without milk)	0

yogurt	0
nuts and seeds	0
white rice	0
cheese	0
green leafy vegetables	0
brown rice	0
ice cream/milk based desserts (gelato, etc)	0
Orange and yellow veggies (squash, pepper, etc.)	0
other grains	0
other dairy (almond milk, soy products, etc.)	0
tomatoes/tomato products	0
margarine, butter, and oils	0
eggs	0
potatoes and other root crops	0
sweet baked goods/desserts	0
poultry (chicken, turkey, duck)	0
citrus fruit (pineapple, kiwi, etc)	0
salty snacks (pretzels, popcorn)	0
beef	0
berries(blue berries, raspberries, etc.)	0
candy (sugar)	0
pork	0
Melons (canatloupe, honeydew, etc.)	0
diet soft drinks	0
lamb, veal, game (deer/rabbit/wild animals)	0
fruit juice	0
other soft drinks	0
fish (raw)	0
orange juices/nectars	0
alcoholic drinks (Vodka, whiskey, rum, etc.)	0
liver/organ meats (chitterlings)	0
white bread	

Liquid meal replacement (Ensure, Special K. etc.)	0
processed meats	0
whole-wheat bread/ Oatmeal Bread	0
Fluid ounces of water	0
beans & legumes (green beans/kidney beans/etc)	0
hot cereal (Oatmeal, Cream of Wheat, etc.)	0
Energy Drinks(Monster, Red bull, etc.)	0
Total	0

Promotion/Advertisement

Which source is the best for obtaining health information?

- Pamphlets, flyers, paper sources (magazines)
- Campus newsletters (via e-mail or print)
- Health Education and classes
- Parent(s)/Family member(s)
- Mobile devices/Online resources
- Religious centers
- Televison
- Radio
- Campus Peer Educators
- Other: (please specify)_____

Which health topics would you like to receive information about while attending TSU? (select all that apply)

- Tobacco Use/Prevention
- Alcohol and drug prevention
- Violence Prevention
- Suicide Prevention
- Cancer Prevention and Information
- Meditation/Sleep Information
- Stress and Mental Health
- Pregnancy/Parenting
- Healthy Relationships
- AIDS/HIV and other STD Prevention

Demographic Characteristics

Gender:

- Male
- Female
- Transgender
- Other

Race/Ethnicity:(check all that apply)

- White
- African-American/Black
- Native American
- Hispanic/Latino
- Asian/Island Pacifer
- Other

Where do you live:

- On-campus
- Off-campus apartment
- At home with family
- Homeless

What diet are you currently following?

- Caloric Restriction
- Low-fat
- Meal skipping
- Increase excercise
- None
- Other

Classification

- Freshman
- Senior
- Other

What is your home zip code?

What is your age range?

- Under 18
- 18-24
- 25-30
- 21-35
- 36-40
- 41-45
- 46-50
- 51-55
- 56-60
- 61-64
- 65 or over