Verizon Health Assessment

Online HQ Text	Answer Options
Page 1	
About You	
What is your height?	____ feet ____inches
What is your weight?	____ lbs
What is your waist measurement?	____ inches
(Optional) What is your ethnic origin?	Asian Black or African-American Hispanic or Latino Indian American Indian or Alaska Native Native Hawaiian or other Pacific Islander White/Caucasian Multi-ethnic Other Unknown
Lab Tests	
Enter the most recent values for each test.	
Blood pressure	Don't know
	___ Systolic
	___ Diastolic
What have you been *told* about your blood pressure?	Radio buttons: 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.
Normal resting pulse rate	Don't know ____ bpm
Body fat %	Don't know ____ %

Total cholesterol	Don't know ____ mg/dL
What have you been *told* about your cholesterol?	Radio buttons: 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.
LDL (bad) cholesterol	Don't know _____ mg/dL
HDL (good) cholesterol	Don't know _____ mg/dL
Triglyceride level	Don't know _____ mg/dL
Blood sugar level	Don't know _____ mg/dL
What type of blood sugar (glucose) measurement was your most recent reading?	Radio buttons: Non-Fasting Fasting Unknown
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Conditions	
Has a doctor ever diagnosed you with any of the following?	
Arthritis	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes

Asthma	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
Cancer (Breast)	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
How severe is it?	Slider: Low Medium Low Medium Medium High High
Cancer (Cervical)	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
How severe is it?	Slider: Low Medium Low Medium Medium High High
Cancer (Colon)	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes

How severe is it?	Slider: Low Medium Low Medium Medium High High
Cancer (Lung)	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
How severe is it?	Slider: Low Medium Low Medium Medium High High
Cancer (Prostate)	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
How severe is it?	Slider: Low Medium Low Medium Medium High High
Chronic back pain or sciatica	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
Chronic neck pain	No Yes
Do you currently have symptoms?	No Yes

Are you currently being treated?	No Yes
Colon polyps	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
Congestive heart failure	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
How severe is it?	Slider: Low Medium Low Medium Medium High High
COPD or emphysema	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
How severe is it?	Slider: Low Medium Low Medium Medium High High
Depression	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes

How severe is it?	Slider: Low Medium Low Medium Medium High High
Diabetes Type 1	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
How severe is it?	Slider: Low Medium Low Medium Medium High High
Diabetes Type 2	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
How severe is it?	Slider: Low Medium Low Medium Medium High High
Heart attack	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes

How severe is it?	Slider: Low Medium Low Medium Medium High High
Heart arrhythmia or irregular heartbeat	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
How severe is it?	Slider: Low Medium Low Medium Medium High High
Heart disease or angina (heart-related chest pain)	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
How severe is it?	Slider: Low Medium Low Medium Medium High High
Osteoporosis	No Yes
Do you currently have symptoms?	No Yes
Are you currently being treated?	No Yes
Stroke	No Yes
Do you currently have symptoms?	No Yes

Are you currently being treated?	No Yes
How severe is it?	Slider: Low Medium Low Medium Medium High High
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Preventive Screenings and Exams	
When did you last have the following health tests or procedures?	
Breast exam by a health care professional	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
Cervical cancer screening (Pap smear)	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	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
Dental exam	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

Digital rectal exam	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
Flu vaccine	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
Glaucoma screening	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
Mammogram	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
Physical exam	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

Prostate cancer screening (PSA)	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
Stool blood test	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
Vision exam	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
Are you pregnant?	Yes Planning to be in the next year No
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Nutrition	
On average, how many servings of the following foods do you eat per day?	
Fruits and vegetables (1⁄2 cup 100% juice; 1 medium piece of fruit; 1 cup chopped, raw, frozen, canned, or 1⁄2 cup cooked vegetables; or 2 cups raw, leafy vegetables)	____ Per day
Whole-grain foods (1 slice whole-grain bread; 1⁄2 cup of cooked oatmeal; 1⁄3 cup cooked brown rice or whole-grain pasta; 3 cups popped popcorn)	____ Per day
Low-fat dairy products (1 cup low-fat milk; 3⁄4 cup low-fat or non-fat yogurt; 1 to 1 1/2 ounces low-fat cheese)	____ Per day

High-quality proteins 2 to 3 ounces of lean meat, poultry, tofu, or fish; 1 egg; 1/2 cup of cooked dry beans; 1 ounce of nuts or seeds	____ Per day
High-fat foods (whole milk, butter, full-fat cheese, ice cream, fatty meats, chips, fried foods, food with saturated or trans fats)	____ Per day
Tobacco Use	
Indicate your tobacco use history.	
Cigarettes	Currently use Previously used Never used
Chewing or smokeless tobacco	Currently use Previously used Never used
Cigars	Currently use Previously used Never used
Pipes	Currently use Previously used Never used
Are you exposed to secondhand tobacco smoke more than once a week for 30 minutes or longer?	Yes No
Alcohol Use	
On an average day, how many alcoholic drinks do you usually consume?	0 1 2 more than 2
1 drink = 1 bottle of beer or wine cooler (12 ounces) 1 glass of wine (5 ounces) 1 shot of 80-proof distilled spirits (1.5 ounces)	
Have you had 5 or more alcoholic drinks in a single sitting in the last 6 months?	Yes No
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Tobacco Usage	
How many years have you smoked cigarettes?	____ [text entry box]
How many years have you used chewing or smokeless tobacco?	____ [text entry box]

How many years have you smoked cigars?	____ [text entry box]
How many years have you smoked pipes?	____ [text entry box]
How many years did you smoke cigarettes?	____ [text entry box]
How many years did you use chewing or smokeless tobacco?	____ [text entry box]
How many years did you smoke cigars?	____ [text entry box]
How many years did you smoke pipes?	____ [text entry box]
Select the number of cigarettes you typically smoke(d).	Less than 10 per day 10-19 per day 20-39 per day 40 or more per day
Select the amount of chewing or smokeless tobacco you typically used(d).	Less than 1 tin per day 1-2 tins per day 3-4 tins per day More than 4 tins per day
Select the number of cigars you typically smoke(d).	1-2 cigars per day 3-4 cigars per day More than 4 cigars per day
Select the number of pipe bowls you typically smoke(d).	Less than 1 bowl per day 1-2 bowls per day 3-4 bowls per day More than 4 bowls per day
As a previous smoker, how long have been free of that type of smoking tobacco? (We recognize that you may be using another type of tobacco.)	15 years or more 10-14 years 5-9 years 1-4 years Less than 1 year
Alcohol Intake	
Answer these questions regarding your alcohol intake.	
Do you ever feel that you should cut down on your drinking?	Yes No
Have people annoyed you by criticizing your drinking?	Yes No
Have you ever felt bad or guilty about your drinking?	Yes No
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hang-over?	Yes No
Exercise	
How often do you do the following kinds of exercise?	

Cardiovascular exercise, including jogging, cardio machines, aerobics, brisk walking, swimming, or any other such exercise	____ Days/week
	____ Minutes/session
Strength-building exercise, including weightlifting, push-ups, sit-ups, yoga, Pilates, or any other such exercise	____ Days/week
	____ Minutes/session
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Emotional Health	
Over the past *2 weeks,* have you felt down, depressed, or hopeless?	Yes No
Over the past *2 weeks* , have you felt little interest or pleasure in doing things?	Yes No
How often do you use stress reducing techniques, including exercise, meditation, prayer, journaling, or any other technique?	Often Sometimes Never
In the past *year* , have you experienced any of the following intensely for 2 weeks or more?	
Feelings of hopelessness or guilt	Yes No
Loss of appetite, weight gain/loss	Yes No
Decreased energy/fatigue	Yes No
Persistent sadness	Yes No
Insomnia/oversleeping	Yes No
Difficulty concentrating/making decisions	Yes No
Persistent or troublesome anxiety	Yes No
In the past *year* , have you experienced problems with any of the following?	
A family member, friend, co-worker or supervisor	Yes No
Death of a loved one	Yes No

Depression	Yes No
Divorce/separation	Yes No
Finances	Yes No
Job loss/fear of job loss	Yes No
Job stress	Yes No
Moving/relocation	Yes No
Violence	Yes No
Your health	Yes No
How strongly do you agree or disagree with the following statements?	
In general, I am satisfied with my job.	Strongly Agree Agree Neutral Disagree Strongly disagree
In general, I am satisfied with my life.	Strongly Agree Agree Neutral Disagree Strongly disagree
In the past year, stress has affected my health or well-being.	Strongly Agree Agree Neutral Disagree Strongly disagree
I receive support from my family or friends.	Strongly Agree Agree Neutral Disagree Strongly disagree
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Healthy Changes	

Indicate your level of commitment or interest in each of the healthy changes below.	
Quit using tobacco	I have no need to. I have been more than 6 months. I have been less than 6 months. I plan to within the next month. I have been less than 6 months. I have no plans to.
Increase my level of cardiovascular exercise	I have no need to. I have been more than 6 months. I have been less than 6 months. I plan to within the next month. I have been less than 6 months. I have no plans to.
Increase my level of strength-building exercise	I have no need to. I have been more than 6 months. I have been less than 6 months. I plan to within the next month. I have been less than 6 months. I have no plans to.
Improve my diet	I have no need to. I have been more than 6 months. I have been less than 6 months. I plan to within the next month. I have been less than 6 months. I have no plans to.
Manage my weight better	I have no need to. I have been more than 6 months. I have been less than 6 months. I plan to within the next month. I have been less than 6 months. I have no plans to.
Get current with my preventive screenings or exams	I have no need to. I have been more than 6 months. I have been less than 6 months. I plan to within the next month. I have been less than 6 months. I have no plans to.

Start a stress reduction program	I have no need to. I have been more than 6 months. I have been less than 6 months. I plan to within the next month. I have been less than 6 months. I have no plans to.
Reduce alcohol use	I have no need to. I have been more than 6 months. I have been less than 6 months. I plan to within the next month. I have been less than 6 months. I have no plans to.
Control my blood pressure	I have no need to. I have been more than 6 months. I have been less than 6 months. I plan to within the next month. I have been less than 6 months. I have no plans to.
Control my cholesterol	I have no need to. I have been more than 6 months. I have been less than 6 months. I plan to within the next month. I have been less than 6 months. I have no plans to.
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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
In the past year, approximately how many times have you:	
Been to the emergency room?	____ times
Missed work due to illness or injury?	____ times
Feedback	
Approximately how long did it take you to fill out this questionnaire?	____ minutes

Contact Information	
Enter your complete phone number, including area code.	
Primary (required)	text box
Alternate (optional)	text box
Indicate which phone number is the better number to reach you.	Primary Alternate