



Today's Date:
(Month) (Day) (Year)

Healthy Communities Health Screening

Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (Month) (Day) (Year)	Race: <input type="radio"/> African American/Black <input type="radio"/> Asian American/Pacific Islander <input type="radio"/> Caucasian/White <input type="radio"/> Hispanic/Latino <input type="radio"/> Native American <input type="radio"/> Other
Height: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (Feet) (Inches)	Ethnicity: Hispanic/Latino <input type="radio"/> Yes <input type="radio"/> No
Weight (lbs): <input type="text"/> <input type="text"/> <input type="text"/>	
Gender: <input type="radio"/> Female <input type="radio"/> Male	

1. Do you currently smoke? Yes No
2. Have you ever smoked in the past? Yes No
3. Have you had any surgery in the past 90 days? Yes No
4. If you answered yes to Q3, was your surgery on your chest, stomach or eye? Yes No
5. Do you have a heart condition? Yes No
6. Do you have tuberculosis, (TB), a chronic bacterial infection? Yes No
7. Are you currently being treated for a respiratory/lung infection? Yes No
8. Do you have hemophilia, a blood disease that affects the blood's ability to clot normally? Yes No
9. Do you have anemia, a condition that decreases healthy red blood cells in the body? Yes No
10. What type of health insurance do you currently have? (please select all that apply):
 Medicare Medicaid Non-government third-party
 Don't know Other No current health insurance
11. When was the last time you visited your healthcare professional for a physical examination?
 Less than 6 months 6 months to a year 1 to 2 years 2 years or more
12. How would you rate your health in the past year? Excellent Good Fair Poor
13. Do you plan to discuss your health screening results with your healthcare professional? Yes No
14. I am currently taking medications for the following conditions (please check all that apply):
 Allergies Diabetes High Blood Pressure Smoking Cessation
 Asthma Enlarged Prostate Migraine Other (please note)
 Depression Erectile Dysfunction Osteoporosis
15. Have you ever been told by a healthcare professional that you have asthma or have you taken medication for asthma? Yes No
(If you answered YES to question 15, please answer questions 16-20. If NO, please proceed to screening.)
16. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?
 All of the time Most of the time Some of the time A little of the time None of the time
17. During the past 4 weeks how often have you had shortness of breath?
 More than once a day Once a day 3 to 6 times a week 1 to 2 times a week Not at all
18. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?
 4 or more nights a week 2 to 3 nights a week Once a week Once or twice Not at all
19. During the past 4 weeks how often have you used your rescue inhaler or nebulizer medication (such as Albuterol)?
 3 or more times a day 1 or 2 times a day 2 to 3 times a week Once a week or less Not at all
20. How would you rate your asthma control during the past 4 weeks?
 Completely controlled Well controlled Somewhat controlled Poorly controlled Not controlled at all