## Personal Health Assessment

**Please mark the most appropriate response**

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

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

- [ ] Yes
- [x] 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?
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 had your blood pressure 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 pressure checked?
- Less than a year ago
- More than a year ago
- I have never had it checked

Have you EVER had a test for high blood sugar or diabetes within the past three years?
- No
- Yes

If Yes, what were you told about your blood glucose results?
- Normal
- High
- Low
- I don't know

How long ago was your blood sugar or diabetes test?
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 attack 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)
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 EVER 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
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 **ALWAYS** 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):
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
<table>
<thead>
<tr>
<th>Food Item</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>yogurt</td>
<td>0</td>
</tr>
<tr>
<td>nuts and seeds</td>
<td>0</td>
</tr>
<tr>
<td>white rice</td>
<td>0</td>
</tr>
<tr>
<td>cheese</td>
<td>0</td>
</tr>
<tr>
<td>green leafy vegetables</td>
<td>0</td>
</tr>
<tr>
<td>brown rice</td>
<td>0</td>
</tr>
<tr>
<td>ice cream/milk based desserts (gelato, etc)</td>
<td>0</td>
</tr>
<tr>
<td>Orange and yellow veggies (squash, pepper, etc.)</td>
<td>0</td>
</tr>
<tr>
<td>other grains</td>
<td>0</td>
</tr>
<tr>
<td>other dairy (almond milk, soy products, etc.)</td>
<td>0</td>
</tr>
<tr>
<td>tomatoes/tomato products</td>
<td>0</td>
</tr>
<tr>
<td>margarine, butter, and oils</td>
<td>0</td>
</tr>
<tr>
<td>eggs</td>
<td>0</td>
</tr>
<tr>
<td>potatoes and other root crops</td>
<td>0</td>
</tr>
<tr>
<td>sweet baked goods/desserts</td>
<td>0</td>
</tr>
<tr>
<td>poultry (chicken, turkey, duck)</td>
<td>0</td>
</tr>
<tr>
<td>citrus fruit (pineapple, kiwi, etc)</td>
<td>0</td>
</tr>
<tr>
<td>salty snacks (pretzels, popcorn)</td>
<td>0</td>
</tr>
<tr>
<td>beef</td>
<td>0</td>
</tr>
<tr>
<td>berries (blue berries, raspberries, etc.)</td>
<td>0</td>
</tr>
<tr>
<td>candy (sugar)</td>
<td>0</td>
</tr>
<tr>
<td>pork</td>
<td>0</td>
</tr>
<tr>
<td>Melons (cantaloupe, honeydew, etc.)</td>
<td>0</td>
</tr>
<tr>
<td>diet soft drinks</td>
<td>0</td>
</tr>
<tr>
<td>lamb, veal, game (deer/rabbit/wild animals)</td>
<td>0</td>
</tr>
<tr>
<td>fruit juice</td>
<td>0</td>
</tr>
<tr>
<td>other soft drinks</td>
<td>0</td>
</tr>
<tr>
<td>fish (raw)</td>
<td>0</td>
</tr>
<tr>
<td>orange juices/nectars</td>
<td>0</td>
</tr>
<tr>
<td>alcoholic drinks (Vodka, whiskey, rum, etc.)</td>
<td>0</td>
</tr>
<tr>
<td>liver/organ meats (chitterlings)</td>
<td>0</td>
</tr>
<tr>
<td>white bread</td>
<td>0</td>
</tr>
</tbody>
</table>
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
- Television
- Radio
- Campus Peer Educators
- Other: (please specify)____________________________

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

<table>
<thead>
<tr>
<th>Topic</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Use/Prevention</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol and drug prevention</td>
<td>0</td>
</tr>
<tr>
<td>Violence Prevention</td>
<td>0</td>
</tr>
<tr>
<td>Suicide Prevention</td>
<td>0</td>
</tr>
<tr>
<td>Cancer Prevention and Information</td>
<td>0</td>
</tr>
<tr>
<td>Meditation/Sleep Information</td>
<td>0</td>
</tr>
<tr>
<td>Stress and Mental Health</td>
<td>0</td>
</tr>
<tr>
<td>Pregnancy/Parenting</td>
<td>0</td>
</tr>
<tr>
<td>Healthy Relationships</td>
<td>0</td>
</tr>
<tr>
<td>AIDS/HIV and other STD Prevention</td>
<td>0</td>
</tr>
</tbody>
</table>

Demographic Characteristics

https://az1.qualtrics.com/ControlPanel/Ajax.php?action=GetSurveyPrintPreview&T=3BWdNHqvmIAVIO3xUqKIJP
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 exercise
- 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