This resident health survey was designed by the Community Advocates, residents with responsibility for promoting excellent and appropriate health thru provision of health information and education to community members.

The purpose of this survey is to develop strategies for collecting information about your knowledge and health beliefs about various health topics.

Please answer the following questions on health to the best of your ability.

Questions

Section #1: Demographics

1. What is your age? _______

2. Are you male or female? (Circle one)

3. What is your highest educational level completed? ______________

4. What is your yearly income? ______________

5. Are you? Single____ Married____ Separated____ Widowed____

6. What is the source of your income? (Circle)
   A. SSI
   B. SSD
   C. VA or other Pension
   D. Employment
   E. Family/other
   F. None

7. What is your ethnic status? (Circle)
   A. Black
   B. White
   C. Asian
   D. Hispanic
   E. Native American
   F. Other

Section #2: Your Doctor

8. Do you presently have a doctor? (If yes skip question # 9.) (Circle)
   A. Yes
   B. No

Continued on the back side
9. Why don't you have a doctor?
   A. No help selecting one
   B. Afraid of doctors
   C. Have not been ill
   D. Have no health insurance

10. How long have you been without a doctor?
    A. 1 year or less
    B. More than 1 year
    C. More than 3 years
    D. More than 5 years

11. How often do you visit your doctor(s)?
    A. Every 3 months
    B. Every 6 months
    C. 1 time per year
    D. Only when ill

12. For what reasons do you visit your doctor(s)?
    A. Regularly scheduled appointments
    B. To see specialists
    C. Only when ill
    D. Forced to

13. Do you trust your doctor? *(Circle one)*
    A. Yes
    B. No
    C. Sometimes

14. Do you follow your doctor(s)’s advice?
    A. Yes
    B. No
    C. Sometimes

15. What is your approximate
    A. Height? ___________
    B. Present weight? ___________
    C. Desired (Normal Weight)? ___________

16. Check The Range of Your Level

<table>
<thead>
<tr>
<th>Blood Pressure Levels</th>
<th>Systolic</th>
<th>Diastolic</th>
<th>Systolic</th>
<th>Diastolic</th>
</tr>
</thead>
<tbody>
<tr>
<td>High is</td>
<td>140 or Above</td>
<td>90 or Above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prehypertension is</td>
<td>120 to 139</td>
<td>80 to 90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal Adult (age 18 or older) is</td>
<td>114 or Below</td>
<td>79 or Below</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
17. Cholesterol, HDL and LDL Levels:

Your score is within which level? (Please Check)
______ total cholesterol levels less than 200 are considered low.
______ total cholesterol levels between 200 and 239 are border line high.
______ total cholesterol levels that are 240 or higher are high.
______ HDL Levels of less than 40 for men and 50 for women are low.
______ LDL levels should optimally be less than 100.
______ LDL levels greater than 129 are considered border line high.
______ LDL levels greater than 129 are considered high.

Check the Range of Your Levels
A. Cholesterol________
B. HDL________
C LDL________

Section #3: Your Physical Health

18. According to listed medical conditions on page 10 of this survey, use the number next to the medical conditions to list your present and past health problems.

19. Rate your knowledge and understanding of your health problems/status. (Circle)
   A. Poor
   B. Fair
   C. Average
   D. Above average

20. Rate how well you care for your health problems or health. (Circle)
   A. Poorly
   B. Fairly
   C. Average
   D. Above Average

21. How often do you have recommended preventive medical screening test performed such as: blood pressure check, colorectal, mammogram (breast), prostate, Pap smear, cholesterol, etc. (Circle)

Section #4: Nutrition

22. How many times per day do you eat? (Circle)
   A. 1 time
   B. 2 times
   C. 3 times
   D. More than 3 times  Continued on the back side
23. How many times per day do you eat the following foods? (*Check*)
   A. Vegetables ___  F. Breads___
   B. Fruits___  G. Grains (all forms)
   C. Meat___  -cereals_______
   D. Poultry___  -rice_________
   E. Fish___  -pasta_________

24. What is your portion size when you eat? (*Circle*)
   A. Snack
   B. Small
   C. Average
   D. Large

25. How often do you eat low fat foods? (*Circle*)
   A. Always
   B. Frequently
   C. Sometimes
   D. Never

26. How often do you drink water? (*Circle*)
   A. Always
   B. Frequently
   C. Sometimes
   D. Never

27. How often do you drink milk? (*Circle*)
   A. Always
   B. Frequently
   C. Sometimes
   D. Never

28. How often do you drink fruit juice? (*Circle*)
   A. Always
   B. Frequently
   C. Sometimes
   D. Never

29. Do you take vitamins? (*Circle*)
   A. Daily
   B. Sometimes
   C. Never

*Continued on the next page*
30. How often do you use salt or sugar? (Circle)
   A. Always
   B. Frequently
   C. Sometimes
   D. Never

31. Which type of cooking oil do you use? (Circle)
   A. Vegetable
   B. Granola
   C. Olive
   D. Other

32. Can you name/describe the basic food groups (Food Pyramid)? (Circle)
   A. Yes
   B. No

33. How often do you drink milk? (Circle)
   A. Always
   B. Frequently
   C. Sometimes
   D. Never

34. How often do you read health information/education materials? (Circle)
   A. Often
   B. 1 time per month
   C. Occasionally
   D. Never

Section #5: Fitness

35. Which of the following do you do when you exercise? (Circle)
   A. Walk
   B. Run
   C. Use exercise equipment
   D. Stretch
   E. None

36. On average, how often do you
   A. Walk? ________
   B. Run? ________
   C. Stretch? ________
   D. Use exercise equipment? ________
   E. Never

Continued on the back side
37. How many times have you participated in an organized fitness class?  \textit{(Circle)}
   A. 1 time
   B. 2 times
   C. More than 2 times
   D. Never

38. How often do you read fitness information/educational materials?  \textit{(Circle)}
   A. 1 time per month
   B. Often
   C. Occasionally
   D. Never

39. Are you aware of the health benefits of exercising on regular bases?  \textit{(Circle)}
   A. Yes
   B. No
   C. Somewhat

Section #6: Your Family Health/History

40. On page 10 of this survey, according to corresponding numbers next to medical conditions, list the health problems and cause of death of the following family members:
   A. Grandfather________Cause of death ____________ Don’t know___
   B. Grandmother________Cause of death ____________ Don’t know___
   C. Father______________Cause of death ____________ Don’t know___
   D. Mother______________Cause of death ____________ Don’t know___
   E. Brother____________ Cause of death ____________ Don’t know___
   F. Sister_______________ Cause of death ____________ Don’t know___
   G. Your children________Cause of death ____________ Don’t know___

41. On average how long do your family members live, such as grandparents, parents, siblings, etc.?  \textit{(Circle)}
   A. Younger than 50 years of age
   B. Over 50 years of age
   C. Over 60 years of age
   D. Over 70 years of age

\textit{Continued on the next page}
42. On page 10 of this survey, according to corresponding numbers next to medical conditions, list the hereditary (genetic) health problems of your living immediate family members:
   A. Grandfather___________
   B. Grandmother__________
   C. Father_______________
   D. Mother______________
   E. Brother_______________
   F. Sister_______________
   G. Your children_________

43. How many of your present or deceased family members experienced the same medical conditions as you? (Circle)
   A. 1 member
   B. 2 or more
   C. 4 or more
   D. 6 or more

Section #7: Alcohol and other Drug Abuse (AODA)

44. How often do you consume any type of alcohol beverage? (Circle)
   A. 1 time per day or less
   B. More than 1 time per day
   C. More than above
   D. Frequently (on regular basis)

45. When you drink alcohol, how many drinks do you consume? (Circle)
   A. 1
   B. 2 or more
   C. 3 to 5
   D. 5 or more

46. Do you use any of the listed drugs? (Circle)
   A. Marijuana
   B. Cocaine (Any form)
   C. Heroin
   D. All of the Above
   E. Other

47. Have you ever had AODA inpatient or outpatient treatment? (Circle)
   A. Yes
   B. No
   C. Do you feel you have a problem with alcohol or other drugs? (Circle) Yes No

Continued on the back side
48. Have anyone in your immediate family ever had AODA inpatient or outpatient treatment? *(Circle)*
   A. Yes
   B. No
   C. One/Some could use
   D. Don’t know

**Section #8: Smoking**

49. How would you describe your smoking habits? *(Circle)*
   A. Never smoked
   B. Used to smoke
   C. Still smoke

50. How many times do you smoke per day? __________

51. How many years has it been since you stopped smoking? __________

52. How often are you exposed to second hand smoke? *(Circle)*
   A. Daily
   B. Often
   C. Sometimes
   D. Never

53. After thinking and answering these survey questions pertaining to your health, do you now feel you possess a clearer understanding of knowledge and health beliefs about various health topics? *(Circle)*
   A. Yes
   B. No
   C. Somewhat
   D. Don’t know

**Section #9: Mental Health**

54. Are you familiar with the following mental health conditions? *(Circle)*
   A. Anxiety/stress/nervousness
   B. Depression
   C. Schizophrenia
   D. None of the Above

55. How well do you handle stress? *(Circle)*
   A. Poorly
   B. Fairly
   C. Somewhat
   D. Well

*Continued on the next page*
56. Of the following, circle how you handle stress. *(Circle)*
   A. Exercise
   B. Socialize
   C. Internalize
   D. Seek treatment

57. Have you ever been diagnosed with mental illness? *(Circle)*
   A. Yes
   B. No
   C. No Response

58. Have you ever been treated, inpatient or outpatient, for mental illness? *(Circle)*
   A. Yes
   B. No
   C. No Response

59. Have immediate family members been treated for mental illness? *(Circle)*
   A. Yes
   B. No
   C. Unsure

If this survey has omitted any medical conditions/topics which particularly affect you or interest you, please mention them to your community health advocates or case management staff.

From the major medical conditions/topics listed on page 10 of this survey, please list the medical conditions/topics you would like to receive information/education about. This will be accomplished through development of an on-site resource room and provision of consistent various presentations on health and medical topics.

Continued on the back side
**Major Medical Conditions/Topics**

1. Alzheimer’s Disease (other dementia)  
2. (ADOA) Alcohol/Drug Abuse  
3. Allergies  
4. Arthritis  
5. Brain Disorders  
6. Cancer (all forms)  
7. Degenerative disc disease  
8. Degenerative joint disease  
9. Diabetes (insulin dependent)  
10. Eye Problems (glaucoma, blindness & other)  
11. Falls (Fractures)  
12. Gastrointestinal (COI)  
13. Geriatrics (Elderly)  
14. Hearing Problems (Deafness)  
15. Heart Disease/all related problems  
16. Hypertension  
17. Infectious Disease  
18. Kidney Disease/Dialysis  
19. Liver Disease  
20. Medication  
21. Mental Illness  
22. Obstetrics/Gynecology (obesity)  
23. Physical Disabilities  
24. Urology/Prostate  
25. Respiratory: Asthma, COPO, Bronchitis  
26. Seizure Disorder  
27. Stroke  
28. Others: Please list.

THANK YOU FOR TAKING OUR SURVEY!!

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