State of Maryland
Employee and Retiree Health and Welfare Benefits Program
Health Assessment

Print Your Full Name: _____

Print Your Health Benefits Carrier Name: _____

Print Your Membership ID Number: _____

QUESTION TEXT
On scale of 1 to 10, where 0 represents the worst possible health, how would you rate your physical health today? Answer:
During the last month, how many days did poor health keep you from your daily activities? Answer:
Do you use tobacco products? (List all types. If none, write none) Answer:
Did you eat healthy all day yesterday? Choose: yes, no, not sure Answer:
During a typical week, do you drink alcohol? If yes, how many? (Note: One drink is equal to one beer, one glass of wine, one mixed drink.) Answer:
In the past week, how often did you have five or more servings of fruits and vegetables? Answer:

In the past week, how often did you exercise for 30 or more minutes?

Answer:

How frequently do you use drugs or medication, including prescription drugs, to help you relax and/or to affect your mood?

Choose: Daily, Multiple times a week, Occasionally, Never

Answer:

Has your physician prescribed any maintenance medication that you **Do not** take as prescribed, or that you **have not** filled?

Answer:

Have you had an annual dental checkup?

Answer:

Have you ever been told by a physician or nurse that you have had any of the following:

- High Blood Pressure Answer:
- High Cholesterol Answer:
- Diabetes Answer:
- Heart Attack Answer:
- Asthma Answer:
- Depression Answer:
- Cancer Answer:

Are you experiencing any other health problems?

Answer:

If yes, how many other health problems are you experiencing? Please enter the number.

Answer:

Over the last month, how many days did you miss an entire day from work duties as a result of problems with your physical or mental health? Please include only days missed for your health, not someone else's health.

Answer:

Over the month, how frequently did you experience little interest or pleasure in doing things? Choose often, sometimes, rarely

Answer:

Over the past day, did you experience the following feelings most of the day?

- Sadness Answer:
- Stress Answer:
- Enjoyment Answer:
- Worry Answer:
- Physical Pain Answer:

What is your approximate weight in lbs?

Answer:

How tall are you ? Answer:

What is your waist measurement in inches?

Answer:

Complete as many of the following results as you can:

- Systolic BP:
- Diastolic BP:
- Fasting glucose:
- Total cholesterol:
- HDL cholesterol:
- LDL cholesterol:
- Triglycerides:

Are there children living at home?

If yes, how many? Answer:

What is your current marital status?

Answer:

Is your health generally, excellent, very good, good, fair, or poor? Choose one.

Answer:

Do you currently see a therapist or counselor for depression? Yes or No

Answer:

Do you have a written Advance Directive? Yes or No

Answer:

Have you discussed your Advance Directive with your physician? Yes or No

Answer: