



10

CIGARETTE SMOKING

How would you describe your cigarette smoking habits?

- Still smoke  Go to question 11
- Used to smoke  Go to question 12
- Never smoked  Go to question 13

11

STILL SMOKE

cigarettes per day	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>

(Go to question 13)

12

USED TO SMOKE

Years	<input type="text"/>	<input type="text"/>	What was the average number of cigarettes per day that you smoked in the 2 years before you quit?
How many years has it been since you smoked cigarettes on a fairly regular basis?	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	

- less than 9
- 10-15
- 16-19
- 20+

13

Do you smoke or use

- pipes?  Yes  No
- cigars?  Yes  No
- smokeless tobacco?  Yes  No

14

How often do you use drugs or medication (including prescription drugs) which affect your mood or help you to relax?

- Almost every day
- Sometimes
- Rarely or never

15

Drinks

How many drinks of alcoholic beverages do you have in a typical week? (one drink = one beer, glass of wine, shot of liquor or mixed drink)

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

16

Times last month

How many times in the last month did you drive or ride when the driver had perhaps too much to drink?

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

17

In the next 12 months how many thousands of miles will you probably drive or ride in each of the following?

A. Car, truck, van or SUV

- 1-1,999
- 2,000-4,999
- 5,000-9,999
- 10,000-14,999
- 15,000-19,999
- 20,000-29,999
- 30,000 miles or more
- do not drive or ride

B. Motorcycle

- 1-999
- 1,000-1,999
- 2,000-2,999
- 3,000-3,999
- 4,000-4,999
- 5,000 miles or more
- do not drive or ride





35

How many hours did you take off from work over the past 2 weeks to take care of sick children, parents or other relatives? (This might include taking children to doctor's appointments, staying home with a sick child or parent or calling doctors or health insurance companies.)



Hours

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

36

Do you have a family history (brother, sister, mother, father, grandparents) of:

- |                     |   |                           |                          |                                    |
|---------------------|---|---------------------------|--------------------------|------------------------------------|
| High Blood Pressure | → | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> I'm not sure |
| Heart Problems      | → | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> I'm not sure |
| Diabetes            | → | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> I'm not sure |
| Cancer              | → | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> I'm not sure |
| High Cholesterol    | → | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> I'm not sure |

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Do you have:

If have currently

		never	in the past	have currently	taking medication	under medical care
Allergies	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Back Pain	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic bronchitis/ emphysema	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic pain	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart problems	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heartburn or acid reflux	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High cholesterol	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menopause	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraine headaches	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other condition	→	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Turn the page. →



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How old were you when your first child was born?

- Younger than 20     25 to 29     Does not apply  
 20 to 24     30 or older

44

How often do you examine your breasts for lumps?

- Monthly     Once every few months     Rarely or never

MEN (Women go to question 46)

45

How often do you examine your testicles for lumps?

- Monthly     Once every few months     Rarely or never

46

- Single (never married)     Married  
 Separated     Widowed  
 Divorced     Other

47

- White (non-Hispanic origin)     Asian or Pacific Islander  
 Black (non-Hispanic origin)     American Indian / Alaskan Native  
 Hispanic     Other

48

- Some high school or less     College graduate  
 High school graduate     Post graduate or professional degree  
 Some college

49

- less than \$35,000     \$75,000 - \$99,999  
 \$35,000 - \$49,999     \$100,000 or more  
 \$50,000 - \$74,999



Turn the page.



50

In the next 6 months, are you planning to make any changes to keep yourself healthy or improve your health?

		Yes	No	Don't Know	Not Needed
Increase physical activity	➔	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lose weight	➔	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reduce alcohol use	➔	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quit or cut down smoking	➔	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reduce fat / cholesterol intake	➔	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lower blood pressure	➔	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lower cholesterol level	➔	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cope better with stress	➔	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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In the next 6 months, would you participate in a program that would help you to enhance your overall health?

Yes     No     I'm not sure

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If available, would you like follow-up information and other services to enhance your health? (If you answer yes, your information may be used only by approved vendors to enhance your health through personal contact or written information.)

Yes     No

**Your privacy comes first!** Your name and identification number are required to confirm your eligibility to take advantage of this Health Risk Appraisal (HRA). Beyond this purpose, your information is considered anonymous. Your data are held in confidence by the University of Michigan Health Management Research Center and are used in an aggregate, anonymous form for reporting and scientific research.

**THANK YOU FOR YOUR PARTICIPATION.**

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PLEASE DO NOT WRITE IN THIS AREA

