

Jackson County Department of Public Health

538 Scotts Creek Rd. Suite 100 • Sylva, NC 28779

Tel: 828-586-8994 • FAX: 828-586-3493

Paula G. Carden

DIRECTOR

Name: _____

DOB: _____

Height: _____ Weight: _____

Race/Ethnicity:

___ White/Caucasian

___ African-American

___ Hispanic/Latino

___ Asian

___ Native American

___ East Indian

___ Middle Eastern

___ Other _____

HEALTH HISTORY

Mark any health condition that occurred in your father, mother, brother (s), or sister (s)

___ coronary heart disease, heart attack, or
coronary surgery before age 55 in men, 65
in women

___ type 2 diabetes

___ osteoporosis or fractures

___ breast cancer

___ colon cancer

*Mark any condition your doctor has told you
that you have.*

___ allergies

___ asthma

___ arthritis

___ chronic back pain

___ chronic lung disease (COPD)

___ chronic sinus problem

___ broken bones/stress fractures in the last 10
years

___ coronary heart disease, angina, coronary by-
pass surgery, or angioplasty

___ cancer (other than skin cancer)

___ diabetes (high blood sugar)

___ stroke or restricted blood flow to head or
legs

MEDICAL CARE

Overall Health

In general would you say it is:

___ excellent

___ very good

___ good

___ fair

___ poor

*Have you had this recommended preventive
exam?*

Physical exam within the last 1-2 years

___ yes ___ no

Prostate (ages 50+) exam within last 1-2 years

___ yes ___ no

Bowel (ages 50+) exam within the last 1-2 years

___ yes ___ no

Annual Flu immunization

___ yes ___ no

Pneumonia immunization (ages 65+)

___ yes ___ no

Pap test in the last 3 years (women)

___ yes ___ no

Mammogram in the last 1-2 years (women 40+)

___ yes ___ no

Mark medications you take regularly.

___ blood pressure

___ cholesterol lowering

___ medication for diabetes/high blood sugar

PHYSICAL ACTIVITY

Exercise Days

*How many days each week do you get at least 30
minutes of moderate to vigorous physical
activity (brisk walking, cycling, aerobics, hard
physical labor, etc.)*

___ none _____5

___ 1 _____6

___ 2 _____7

___ 3

___ 4

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Physical Activity Status

Mark the response that best describes your current activity level.

- I have no regular exercise program; generally avoid walking or exertion when possible.
- I occasionally walk for pleasure or exercise sufficiently to cause heavy breathing or perspiration (sweat)
- I get regular exercise in work or recreation requiring modest physical activity, such as golf, yard work, calisthenics, weight lifting, table tennis; up to 1 hour per week.
- I get regular exercise in work or recreation requiring modest physical activity, such as golf, yard work, calisthenics, weight lifting, table tennis; more than 1 hour per week.
- I participate regularly in more active physical exercise (brisk walking, jogging, swimming, cycling, rowing, active sports like tennis or handball). If Yes, indicate below how much time you spend exercising each week: ___

Time Spent Exercising Each Week

Indicate how much time you spend exercising each week.

- less than 1 hour per week
- 1 hour, or run up to 5 miles weekly
- 2 to 3, or run up to 6 to 10 miles weekly
- 4 to 5, or run up to 6 to 10 miles weekly
- 6 to 8 hours, or run up to 16 to 20 miles weekly
- 9 to 11 hours, or run up to 21 to 25 miles weekly
- 12 or more hours, or run over 25 miles weekly

EATING PRACTICES

Whole Grains

How many servings of whole-grain breads and cereals do you eat daily? 1 serving=1 slice of whole-wheat bread; ½ C cooked oatmeal, brown rice, or whole-grain cereal; 2/3 C ready-to-eat whole-grain cereal

- 0
- 1
- 2
- 3
- 4
- 5
- 6+

Fruits

How many cups do you eat daily? 1 cup equivalents: 1 medium apple, orange; 1 C berries or cut fresh fruit; ½ C cooked fruit; ¾ C (6oz.) 100% fruit juice

- 0 4+
- 1/2
- 1
- 1 ½
- 2
- 2 ½
- 3
- 3 ½

Vegetables

How many cups do you eat daily? 1 C raw or cooked veggies, 2 C salad greens, 1 C (8 oz.) veg. juice

- 0 4+
- 1/2
- 1
- 1 ½
- 2
- 2 ½
- 3
- 3 ½

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Protein Food-kind eaten:

What kind of protein foods do you eat most often?

high-fat meats

low-fat meats

plant proteins

Nuts/Seeds

How many servings do you eat weekly? 1

serving=1/2-1 oz. nuts (e.g., almonds, cashews, peanuts, etc.) or seeds (e.g., sunflower, pumpkin, etc.) or 2T nut butter

0

1

2

3

4

5

6+

Sweets

How many servings do you eat daily? 1 serving-3-4 T sugar, 2T syrup or jelly, 8 oz. soft drink, or desserts (e.g., candy, cookie, 1/2 C ice cream, 1 sm. piece cake or pie, etc.)

0

5+

1

2

3

4

Salt

How much salt do you use?

use salt sparingly and limit salty foods

don't think about limiting salt or salty foods

like salt, often salt foods or eat salty foods

SUBSTANCE ABUSE

Smoking Status

Select your current smoking status

never smoked

quit smoking

presently smoke

MENTAL AND SOCIAL FACTORS

Happiness

All in all, how happy are you?

unhappy

pretty happy

very happy

Satisfaction

In general, how satisfied are you with your life?

very satisfied and happy

mostly satisfied

not very satisfied

dissatisfied/unhappy

Sleep Hours

How many hours of sleep do you usually get daily?

less than 6

6-6.9 hours

7-8 hours

more than 8 hours

SAFETY

Seat Belts

When driving or riding in a car, what percentage of the time do you wear a seat belt?

0

25%

50%

70%

90%

100%

Child Safety Seats

When children ride in your car, are they always buckled into an approved child safety or booster seat?

yes

no

does not apply

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Sun

Are you careful to limit excess sun exposure and avoid sunburns?

- always
 sometimes
 seldom or unsure

Helmets

Do you always wear a helmet when riding a motorcycle, cycling, skiing, inline skating, etc.?

- yes
 no
 does not apply

Health Interests

Mark any of the following health improvement opportunities you would like to be notified of if available.

- nutrition/healthy eating
 weight management
 group fitness class
 walking group
 cholesterol reduction
 blood pressure reduction
 reducing diabetes risk
 men's health issues
 reducing coronary risk
 reducing cancer risk
 women's health issues

Notification-To be notified method

What is your preferred contact method?

- email
 phone
 mailing address

Contact Time

When is the best time to contact you?

- morning
 afternoon
 evening

Tetanus/Tdap within the last 5 years?

- yes
 no

Received Shingles Vaccine?

- yes
 no

Eye Exam last 12 months?

- yes
 no

Do you use Smokeless Tobacco?

- yes
 no

CLINICAL USE ONLY

Health Tests:

Clinical Height	_____
Clinical Weight	_____
Systolic Blood Pressure	_____
Diastolic Blood Pressure	_____
Hemoglobin A1c	_____
PSA Test	_____
Total Cholesterol	_____
HDL Cholesterol	_____
LDL Cholesterol	_____
Triglycerides	_____
Blood Glucose	_____