**Form 9 Social History**

# PHYSICAL ACTIVITY

On the past 7 days, how many days did you exercise?

On days when you exercised, for how long did you exercise (in minutes)?

How intense was your typical exercise?

 Light(like stretching or slow walking)

 Moderate (like brisk walking)  Heavy (like jogging or swimming)

 Very heavy (like fast running or stair climbing)

 I am currently not exercising

# TOBACCO USAGE

In the last 30 days, have you used tobacco?

 Yes  No

Smoked

 Yes  No

Used a smokeless tobacco product

 Yes  No

If yes to either, would you be interested in quitting tobacco use within the next month?

 Yes  No

# ALCOHOL USE

In the past 7 days, on how many days did you drink alcohol?

On the days you drank alcohol, how often did you have 5 or more alcoholic drinks for men, 4 more for women and those men and women 65 years or older

 Never  Once during the week  2-3 times during the week

 more than 3 times during the week

Did you ever drive after drinking, or ride with with a driver who has been drinking?

 Yes  No

# NUTRITION

In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving=1 cup of fresh vegetables, 1/2 cup of cooked vegetables, or 1 medium piece of fruit

In the past 7 days, how many servings of fiber or whole grain foods did you typically eat each day? (1 serving=1 slice of 100% whole wheat bread,e 1 cup of whole-grain or high fiber ready-to-eat cereal, 1/2 cup of cooked cereal such as oatmeal, or 1/2 cup of cooked brown rice or whole wheat pasta)

In the past 7 days, how many servings or high-fat foods did you typically eat each day? (examples include fried chicken, fried fish, bacon, French fries, corn chips, coughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese or mayonnaise)

In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?

# SEAT BELT USE

Do you always fasten your seatbelt, when you are in a car?

 Yes  No

# DEPRESSION

In the past 2 weeks, how ofter have you felt down, depressed, or hopeless?

 Almost all of the time  Most of the time  Some of the time

 Almost never

In the past 2 weeks, how often have you felt little interest or pleasure in doing things?

 Almost all the time  Most of the time  Some of the time

 Almost never

Have your feeling caused you distress or interfered with your ability to get along socially with family or friends?

 Yes  No

# ANXIETY

In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

 Almost all the time  Most of the time  Some of the time

 Almost never

In the past 2 weeks, how oftern were you not able to stop worrying or control your worrying?

 Almost all the time  Most of the time  Some of the time

 Almost never

# HIGH STRESS

How often is stress a problem for you in handling such things as: Your health? You finances? Your family or social relationships? Your work?

 Never or rarely  Sometimes  Often

 Always

# SOCIAL EMOTIONAL SUPPORT

How often do you get the social and emotional support you need?

 Always  Usually  Sometimes

 Rarely  Never

# PAIN

In the past 7 days, how much pain have you felt?

 None  Some A lot

# GENERAL HEALTH

In general, would you say your health is:

 Excellent  Very good  Good

 Fair  Poor

How would you describe the condition of your mouth and teeth-including false teeth and dentures?

 Excellent  Very good  Good

 Fair  Poor

# ACTIVITIES OF DAILY LIVING

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

 Yes  No

# INSTRUMENTAL ACTIVITIES OF DAILY LIVING

In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications

 Yes  No

# SLEEP

Each night, how many hours of sleep do you usually get?

Do you snore or has anyone else told you that you snore?

 Yes  No

In the past 7 days, how often have you felt sleepy during the daytime?

 Always  Usually  Sometimes

 Rarely  Never

# BIOMETRIC MEASURES-SELF REPORTED

Blood Pressure-If your blood pressure was checked within the past year, what was it when it was last checked?

 Low or normal (at or below 120/80)

 Borderline high (120/80 to 139/89  High (140/90 or higher)  Don't know/not sure

Cholesterol-If you cholesterol was checked with the past year, what was your total cholesterol when it was last checked?

 Desirable (below 200)  Borderline high ((200-239)  High (240 or higher)

 Don't know/not sure

Blood glucose-If your glucose was checkeed, what was your fasting blood glucose level (blood sugar) the last time it was checked?

 Desirable (below 100)  Borderline high (100 -125)  High (126 or higher)

 Don/t know/not sure

If diabetic, and if you have had your hemoglobin A1C lever]l checked in the past year, what was it the last time you had it checked?

 Desirable (6 or lower)  Borderline high (7)  High (8 or higher)

 Don't know/not sure

# OVERWEIGHT/ OBESITY

What is your height without shoes?

What is your weight in pounds?