Please answer the following questions and return it in the envelope provided within 1-2 weeks. This will help us create better programs for women in Nebraska!

You can take this survey online if you prefer by going to this link: https://www.surveymonkey.com/r/EWMAssessment

Thanks! -EWM Staff

<table>
<thead>
<tr>
<th>DIET &amp; PHYSICAL ACTIVITY</th>
<th>1. How much fruit do you eat in an average day? <em>(1 cup equals 1 large banana or 1 medium apple)</em></th>
<th>_____ Cups</th>
<th>DK*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. How many vegetables do you eat in an average day? <em>(1 cup equals 12 baby carrots or 1 ear corn)</em></td>
<td>_____ Cups</td>
<td>DK*</td>
<td></td>
</tr>
<tr>
<td>3. Do you eat fish at least two times a week?</td>
<td>Yes</td>
<td>No</td>
<td>DK*</td>
</tr>
<tr>
<td>4. How many servings of grain products do you eat in a day? <em>(serving equals 1 slice whole wheat bread, 3 cups popped popcorn, 1/2 cup rice/pasta, 3/4 cup oatmeal)</em></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4a. Of these servings, how many are whole grain?</td>
<td>Less than half</td>
<td>About half</td>
<td>More than half</td>
</tr>
<tr>
<td>5. Do you drink less than 36 ounces of beverages with added sugars weekly? <em>(3 (12 ounce) cans regular soda, juice, alcohol, specialty drinks)</em></td>
<td>Yes</td>
<td>No</td>
<td>DK*</td>
</tr>
<tr>
<td>6. Are you currently watching or reducing your sodium or salt intake?</td>
<td>Yes</td>
<td>No</td>
<td>DK*</td>
</tr>
<tr>
<td>7. How many minutes of physical activity do you get in a WEEK? <em>(walking/running, aerobic dancing, water aerobics, general gardening, bicycling)</em></td>
<td>_____ Minutes</td>
<td>DK*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIGH BLOOD PRESSURE</th>
<th>HIGH CHOLESTEROL</th>
<th>DIABETES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has your doctor, nurse or other health professional EVER told you that you have:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2. Do you take any medication prescribed by your doctors NOW to lower:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3. During the past 7 days, how many days (including today) did you take your medication as prescribed:</td>
<td>_____ Days</td>
<td>DK*</td>
</tr>
<tr>
<td>4. On days you did not take your medication as prescribed, please tell us why:</td>
<td>Cost</td>
<td>Forgot to take</td>
</tr>
<tr>
<td>5. Do you check your blood pressure when you are not at the doctor’s office (at home, at pharmacy, or at a store, etc.)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5a. If no, provide reason:</td>
<td>No, never told to check</td>
<td>No, don’t know how to check</td>
</tr>
<tr>
<td>5b. If yes, how often do you check your blood pressure:</td>
<td>Multiple times a day</td>
<td>Daily</td>
</tr>
<tr>
<td>5c. If yes, do you share your blood pressure numbers with your doctor that you take at home, the pharmacy or a store?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
1. Have you been diagnosed by a healthcare provider as having any of these conditions: (mark all that apply)

- Coronary Heart Disease/Chest Pain:  ○Yes  ○No  ○DK*
- Congenital Heart Defects:  ○Yes  ○No  ○DK*
- Heart Failure:  ○Yes  ○No  ○DK*
- Stroke/Transient Ischemic Attack (TIA):  ○Yes  ○No  ○DK*
- Vascular Disease:  ○Yes  ○No  ○DK*
- Heart Attack:  ○Yes  ○No  ○DK*

2. Are you taking aspirin daily to help prevent a heart attack or stroke?  ○Current Smoker  ○Quit (1-12 months ago)  ○Quit (More than 12 months)  ○Never Smoked

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**SMOKING**

1. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)  ○Current Smoker  ○Quit (1-12 months ago)  ○Quit (More than 12 months)  ○Never Smoked

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**HEART**

1. Have you been diagnosed by a healthcare provider as having any of these conditions: (mark all that apply)

- Coronary Heart Disease/Chest Pain:  ○Yes  ○No  ○DK*
- Congenital Heart Defects:  ○Yes  ○No  ○DK*
- Heart Failure:  ○Yes  ○No  ○DK*
- Stroke/Transient Ischemic Attack (TIA):  ○Yes  ○No  ○DK*
- Vascular Disease:  ○Yes  ○No  ○DK*
- Heart Attack:  ○Yes  ○No  ○DK*

2. Are you taking aspirin daily to help prevent a heart attack or stroke?  ○Current Smoker  ○Quit (1-12 months ago)  ○Quit (More than 12 months)  ○Never Smoked

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**DAILY LIFE**

1. Thinking about your physical health, which includes physical illness and injury, on how many days during the past 30 days was your physical health not good?  ____ Days  ○DK*

2. Thinking about your mental health, which includes stress, depression, and problems with emotions, on how many days during the past 30 days was your mental health not good?  ____ Days  ○DK*

3. During the past 30 days, on about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?  ____ Days  ○DK*

4. Are you limited in any activities because of physical, mental or emotional problems?  ○Yes  ○No  ○DK*

5. Do you now have any health problems that requires you to use special equipment, such as a cane, a wheelchair, a special bed or a special telephone?  ○Yes  ○No  ○DK*

5a. If yes, what type of disability?  ○Emotional  ○Physical  ○Intellectual  ○Sensory

6. Over the past 2 weeks, how often have you been bothered by any of the following problems:

6a. Little interest or pleasure in doing things:  ○Not at all  ○Several days  ○More than half  ○Nearly every day

6b. Feeling down, depressed, or hopeful:  ○Not at all  ○Several days  ○More than half  ○Nearly every day

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**REQUIRED: FOR HEALTH COACHES USE ONLY**

Height (inches): ____________  Weight (pounds): ____________
Waist Circumference (inches): ______________

BP 1: ________/_________  BP 2: ________/_________

Client fasted 9 hrs:  ☐Yes  ☐No

Total Cholesterol**: ________________

**If TC is >240 WW REQUIRES an additional cholesterol test.

HDL: ________  Triglycerides: ________  LDL: ________
Non-HDL: ________  TC/HDL: ________

Cholesterol test performed by:

☐Primary Care Provider  ☐Local Health Department by Cholestech Machine  ☐Other __________________________

What Healthy Behavior Support Services did you participate in?

☐National Diabetes Prevention Program (NDPP)  ☐Living Well  
☐Check. Change. Control.  ☐Walk & Talk Toolkit  
☐Health Coaching  ☐Other __________________________

EWM would like to share test results with a preferred physician. What is the name/address/phone number of preferred physician:

Physician Name: _______________________________________
Address: _______________________________________________
Phone Number: (_________)_______________________________

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