Your Health Risk Assessment and Biometric Screening

The information below will help you prepare for your health risk assessment and biometric screening and know what to expect on the day of your screening.

- **Complete your health risk assessment questionnaire before your screening appointment. This will take about 15 minutes.**
  - Use a pencil to answer the questions
  - Fill in the circle that represents your answer
  - Return your completed questionnaire to Quartz one week prior to your biometric screening appointment
- **Plan ahead for your biometric screening appointment**
  - Do not eat or drink anything other than water for 10 hours prior to your appointment
  - Drink water and be well hydrated during the 10-hour fast
  - Take all of your medications as directed except for medications taken with food. Bring medications that you take with food to your appointment
  - Wear clothing that will allow for blood pressure measurement above the elbow without binding
  - Be on time so that all who have signed up can be served at the requested time
  - Avoid vigorous exercise or nicotine four hours before your appointment
  - Avoid applying hand lotion the morning of your health screening as it may interfere with the blood analysis of the finger stick
- **What to expect at your screening**
  - Full lipid panel from a finger-stick blood test, with results that include total, HDL (good) and LDL (bad) cholesterol, triglycerides and glucose
  - Blood pressure measurement
  - Body Mass Index (BMI)

Your Biometric Screening Appointment

Your appointment is scheduled for:

Day / Date: ______________________________ Time: ________________

Location: ____

If you have any questions, please contact Quartz's Wellness Representatives through Ask a Question within Quartz MyChart at QuartzMyChart.com or call (800) 362-3310.

QA00189 (0519)

Health Risk Assessment

Quartz

____ _______ _________________________________ ______/______/________ ○ Female ○ Male
Last Name | MI | First Name | Date of Birth (m/dd/yyyy)

Subscriber Number ________ ________ ________ ________ ________ ________ ________ ________ ________
(This is the nine digit subscriber number found on your ID card.)
Please Note: If you are not a Quartz member, enter N/A for the subscriber number.
____

____
Employer Name
Please Note: If you are completing this for an employer other than your own, please list that employer's name.

____ ____ ______ ________________ ______________________
Street Address | City | State | ZIP Code | Phone Number

Read the Health Assessment Notice below, describing how your personal information will be safeguarded and used to develop your report.

Health Assessment Notice

Congratulations for choosing to participate in the **Health Assessment**. Consider this assessment as your first step to better health. By choosing to take personal responsibility for your good health now, you may live a longer, healthier and happier life. This assessment is designed for adults 18 years or older.

Use of Personal Information. We retain the information you submit in the course of taking the **Health Assessment**. Your answers to the **Health Assessment** will be disclosed in aggregate form. By aggregate form, we mean that your data will be combined with those of other participants in a manner which does not personally identify you. We have taken steps to fully comply with laws and regulations on the use of personal information. Additionally, in the course of providing services associated with the **Health Assessment** and other products, we have access to your personal information. A member of our Quality Management and Population Health team may contact you depending on your responses to certain questions. We will transcribe your responses from this paper Health Assessment to the Personal Wellness Profile so you are able to access your responses electronically through MyChart. You may delete your Wellness Profile at any time; however, we cannot guarantee that your information in aggregate form will be completely removed from the system.

Terms of Use. By participating in the **Health Assessment**, you agree that the results of the assessment will be used for instructive purposes only and that the **Health Assessment** is not intended to and cannot replace the advice of a medical professional. You should not rely on the **Health Assessment** for diagnosis or treatment. All people who display disease symptoms fall into certain high risk categories, and/or who receive abnormal laboratory test results should consult a physician before embarking on any course of action or any lifestyle change. We are not liable for any health consequences resulting from your participation in this program.

Consent. This policy and notice may change at any time. This notice contains our policy with respect to our security and privacy practices. By signing below, I acknowledge that I have read, understand and agree to the above and assert that I am at least 18 years of age.

I agree to the Terms of Use

X____ ____________________
Signature | Date

Send completed forms to:
Mail: Quartz, 840 Carolina Street, Sauk City, WI 53583
Fax: (608) 644-2003
Email: Wellness@QuartzBenefits.com

Disclaimer: If you choose to submit this form via email, be advised that many email services are unsecure (unencrypt) and there is some level of risk that your PHI could be read or otherwise accessed by a third party while in transit.

Questions? Contact a Quartz wellness representative at **(800) 362-3310**.

For Office Use Only

Date entered:_______________ Entered by:________________________

Date audited:_______________ Audited by:________________________

Please complete the entire questionnaire by fully shading in the appropriate circle based on your answer.
Please note: If any information is left blank, the questionnaire will be returned to you.

HEALTH VIEW

General Health

Complete the following statement: "In general, my overall health is..." (Fill in only one.)

- ◯ excellent
- ◯ very good
- ◯ good
- ◯ fair
- ◯ poor

Your Current Health

Do you have, or have you been told that you have any of the following health conditions:
(Fill in all that apply or leave blank if not applicable.)
Spouses of employees: please skip this question, as it applies only to the employee.

- ◯ stroke
- ◯ asthma
- ◯ diabetes
- ◯ arthritis
- ◯ back pain
- ◯ depression
- ◯ osteoporosis
- ◯ high cholesterol
- ◯ cancer
- ◯ high blood pressure
- ◯ chronic bronchitis, COPD
- ◯ angina, congestive heart failure or heart attack
- ◯ heartburn
- ◯ headaches
- ◯ anxiety
- ◯ allergies

PREVENTIVE HEALTH

When was your last physical (leave blank if you can't remember)? _____ / _____ / __________
Month Date Year

Do you have regular pap smear and/or HPV test to screen for cervical cancer?

- ◯ yes
- ◯ no
- ◯ not applicable

When was your last pap smear (leave blank if you can't remember)? _____ / _____ / __________
Month Date Year

Have you ever had an abnormal pap smear? (Fill in only one.)

- ◯ yes
- ◯ no

Did you follow up as recommended by your provider? (Fill in only one.)

- ◯ yes
- ◯ no

Have you ever had a mammogram? (Fill in only one.)

- ◯ yes
- ◯ no
- ◯ not applicable

Date of last mammogram: _____ / _____ / __________
(Leave blank if not applicable.) Month Date Year

Do you have a mammogram performed yearly? (Fill in only one.)

- ◯ yes
- ◯ no
- ◯ not applicable

Do you receive at least 1200 mg/day of calcium? (Fill in only one.)

- ◯ yes
- ◯ no
- ◯ not sure

Have you ever had a colonoscopy or other colon cancer screening tests (age 50 or older)? (Fill in only one.)

- ◯ yes
- ◯ no

Have you ever had a PSA test to screen for prostate cancer? (Fill in only one.)

- ◯ yes
- ◯ no
- ◯ not applicable

Have you had a flu shot in the last 12 months? (Fill in only one.)

- ◯ yes
- ◯ no

NUTRITION

Breakfast

How often do you eat breakfast? (Fill in only one.)

- ◯ every day
- ◯ most mornings
- ◯ two or three times per week
- ◯ seldom or never eat breakfast

Snacks

How often do you eat snack foods between meals (chips, pastries, soft drinks, candy, ice cream, cookies)? (Fill in only one.)

- ◯ three or more times per day
- ◯ once or twice per day
- ◯ few times per week
- ◯ seldom or never eat typical snacks

Salt

How often do you add salt to your food or eat salty foods (chips, pickles, soy sauce)? (Fill in only one.)

- ◯ seldom or never
- ◯ some meals
- ◯ most meals
- ◯ nearly every meal

Fat Intake

Indicate the proportion of saturated and unsaturated fat you usually eat

SATURATED FAT EXAMPLES

- Solid oils at room temperature (i.e., Coconut or Palm oil)
- Butter
- Whole milk
- Cream
- Cheese
- Lard
- Fatty meats

UNSATURATED FAT EXAMPLES

- Plant-based liquid oils at room temperature (i.e. Canola or Olive oil)
- Nuts
- Seeds
- Olives
- Avocados
- Fish

(Fill in only one.)

- ◯ eat only saturated fat
- ◯ eat more saturated fat than unsaturated fat
- ◯ eat saturated and unsaturated fats in equal amounts
- ◯ eat more unsaturated fat than saturated fat
- ◯ eat only unsaturated fat

Breads and Grains

Indicate the kinds of breads and grains you usually eat.

REFINED GRAIN EXAMPLES

- White rice
- Pasta made with semolina or white flour
- White bread or white rolls
- Typical cold breakfast cereals
- Baked goods made with white flour

WHOLE-GRAIN EXAMPLES

- Brown rice
- Whole wheat pasta
- Whole wheat bread
- Hot breakfast cereals, such as rolled oats or bran
- Gluten-free grains, such as quinoa and millet

(Fill in only one.)

- ◯ nearly always eat refined grain products
- ◯ eat mostly refined grain products, some whole-grain
- ◯ eat both about the same
- ◯ eat primarily whole-grain products, some refined
- ◯ eat only whole-grain products or gluten-free products or no grains

Fruits and Vegetables

How many servings of fruits and vegetables do you eat daily? (one serving = 1 cup fresh, ½ cup cooked, 1 medium size fruit, or ¾ cup juice). (Fill in only one.)

- ◯ one or less
- ◯ two daily
- ◯ three daily
- ◯ four daily
- ◯ five or more daily

Sweets and Desserts

How many servings of cookies, cakes, donuts, candy, soda, or packets of sugar do you eat daily? (Fill in only one.)

- ◯ one or less
- ◯ two daily
- ◯ three daily
- ◯ four daily
- ◯ five or more daily

EXERCISE

Physical Activity

How many days per week do you participate in at least 20-30 minutes of physical activity?
Moderate = brisk walk, enough to break a light sweat, but without becoming winded.
Vigorous = running, enough to break a heavy sweat and experience heavy breathing. (Fill in only one.)

- ◯ none
- ◯ one day of moderate exercise
- ◯ two days of moderate exercise
- ◯ three days of moderate OR one day of vigorous exercise
- ◯ four days of moderate OR two days of vigorous exercise
- ◯ five days of moderate OR three days of vigorous exercise
- ◯ six days of moderate OR four days of vigorous exercise
- ◯ seven days of moderate OR more than four days of vigorous exercise

Strength Exercises

How many days a week do you engage in strength training exercises? (Fill in only one.)

- ◯ none
- ◯ once a week
- ◯ twice a week
- ◯ three or more times a week

Stretching Exercises

How many times per week do you do stretching exercises to improve the flexibility of your back, neck, shoulders and legs? (Fill in only one.)

- ◯ none
- ◯ once a week
- ◯ twice a week
- ◯ three or more times a week

EMOTIONAL/STRESS

Emotional Health

During the last two weeks has feeling down, depressed or hopeless bothered you? (Fill in only one.)

- ◯ yes
- ◯ no

During the last two weeks, has little interest or little pleasure in doing things bothered you? (Fill in only one.)

- ◯ yes
- ◯ no

Emotional Problems

In the past month, have you felt any of the following? (Select all that apply.)

- ◯ downhearted or sad
- ◯ angry or hostile
- ◯ nervous or uptight
- ◯ that you are receiving good support from friends and family
- ◯ that interesting and challenging situations fill your life

Social Activity

During the past four weeks, to what extent has your physical health or an emotional problem interfered with your normal activities with family, friends, neighbors, or groups? (Fill in only one.)

- ◯ none at all
- ◯ slightly
- ◯ moderately
- ◯ quite a bit
- ◯ extremely

Coping Status

How well do you feel you are coping with your current stress load? (Fill in only one.)

- ◯ coping very well
- ◯ coping fairly well
- ◯ have trouble coping at times
- ◯ often have trouble coping
- ◯ feel unable to cope

Do you have good support from your family and friends? (Fill in only one.)

- ◯ yes
- ◯ no

During the past year have you had any major life or work changes? (Fill in only one.)

- ◯ yes
- ◯ no

Stress Signals

Select any item below that applies to you: (Fill in all that apply.)

Spouses of employees: please skip this question, as it applies only to the employee.

- ◯ minor problems overwhelm me
- ◯ find it difficult to get along with people
- ◯ nothing seems to give me pleasure anymore
- ◯ unable to stop thinking about my problems
- ◯ feel frustrated, impatient, or angry much of the time
- ◯ feel tense or anxious much of the time

Stress reduction techniques (things like exercise, reading, journaling, drawing, meditation, etc.) are useful in managing daily stress. How often do you incorporate stress reduction techniques into your week? (Fill in only one.)

- ◯ daily
- ◯ most days
- ◯ few days
- ◯ never

Sleep

How often do you get at least 7 hours of sleep per night? (Fill in only one.)

- ◯ always
- ◯ most of the time
- ◯ less than half the time
- ◯ seldom or never

SAFETY

Automotive

Do you wear a seat belt in the car? (Fill in only one.)

- ◯ yes
- ◯ no

How often do you wear a seat belt? (Fill in only one.)

- ◯ always
- ◯ most of the time
- ◯ less than half the time
- ◯ seldom or never

Home

Do you have a smoke detector in your home? (Fill in only one.)

- ◯ yes
- ◯ no
- ◯ unsure

Do you have a carbon monoxide detector in your home? (Fill in only one.)

- ◯ yes
- ◯ no
- ◯ unsure

Self

Do you regularly apply sunscreen of SPF 15 or greater? (Fill in only one.)

- ◯ yes
- ◯ no
- ◯ sometimes

Within the last 12 months, have you been in a relationship in which threats, pushing, grabbing, hitting, kicking, breaking things or other harmful behavior was used? (Fill in only one.)

- ◯ yes
- ◯ no

TOBACCO

Smoking Status

Select the item below that applies to you: (Fill in only one.)

- ◯ have never smoked
- ◯ quit smoking two or more years ago
- ◯ quit smoking one to two years ago
- ◯ quit smoking 6-12 months ago
- ◯ quit smoking 0-5 months ago
- ◯ currently smoke pipe or cigar only
- ◯ currently smoke less than 10 cigarettes daily
- ◯ currently smoke 10 or more cigarettes daily

Chewing Tobacco

Do you use chewing tobacco? (Fill in only one.)

- ◯ yes
- ◯ no

ALCOHOL

Number of Drinks

How many alcoholic drinks do you usually consume each week (one drink = a 12 oz. beer or wine cooler, 5 oz. wine, or 1.5 oz. distilled liquor)? (Fill in only one.)

- ◯ zero
- ◯ one to seven
- ◯ 8 to 14
- ◯ 15 to 20
- ◯ 21 or more

Have you had 5 or more alcoholic drinks in a single sitting in the last six months? (A single sitting is defined by the CDC as two hours or less.) (Fill in only one.)

- ◯ yes
- ◯ no

Drinking and Driving

Do you ever drive while under the influence of alcohol or do you ever ride with a person who is under the influence of alcohol? (Fill in only one.)

- ◯ yes
- ◯ no

Medications and Drugs

During the past month, how often have you taken medications not prescribed to you or substances other than over-the-counter medication, supplements, teas to help you sleep? (Fill in only one.)

- ◯ frequently
- ◯ sometimes
- ◯ rarely
- ◯ never

READINESS TO CHANGE

Indicate how ready you are to make changes or improvements to your health in the following areas

NOTE: Fill in one bubble per row for each question.

	Have not thought about changing	Plan a change in the next 6 months	Plan to change this month	Recently started doing this (0-5 months)	Do this regularly (6 months or more)
Be physically active most days	◯	◯	◯	◯	◯
Eat mostly health foods	◯	◯	◯	◯	◯
Live smoke and tobacco free	◯	◯	◯	◯	◯
Achieve/maintain healthy weight	◯	◯	◯	◯	◯
Handle stress well	◯	◯	◯	◯	◯
Live an overall healthy lifestyle	◯	◯	◯	◯	◯

PRODUCTIVITY

Productivity

Each of the following questions relates to your last two weeks at work:

NOTE: Fill in one bubble per row for each question.

	None of the time (0%)	A slight bit of the time	Some of the time (about 50%)	Most of the time	All of the time (100%)	Does not apply to my job
How much of the time did your physical or emotional health make it difficult for you to work your scheduled hours?	○	○	○	○	○	○
How much of the time were you able to sit, stand, or stay in one position while working for over 15 minutes without difficulty caused by physical or emotional health?	○	○	○	○	○	○
How much of the time did your physical or emotional health make it difficult for you to complete your work?	○	○	○	○	○	○
How much of your time did your physical or emotional health make it difficult for you to complete your work without mistakes?	○	○	○	○	○	○

CULTURAL AND HEALTH PART 1

Cultural and Health Needs and Interests

Please take a few minutes to complete this survey. Your specific answers will be completely anonymous. To ensure your anonymity, an independent health and wellness partner has been hired to design the survey and process the results. Questionnaires will be processed anonymously, and the findings will be reported in an aggregate format to the organization.

NOTE: Fill in one bubble per row for each question.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Policies and procedures here make it easy to do work	○	○	○	○	○
I am proud to be associated with this company	○	○	○	○	○
Employees are able to support one another	○	○	○	○	○
Management pays careful attention to employee suggestions	○	○	○	○	○
I feel physically safe at my job	○	○	○	○	○
Work-life balance is supported at my company	○	○	○	○	○
Company communications are frequent	○	○	○	○	○
The people at my company always behave in an ethical manner	○	○	○	○	○

CULTURAL AND HEALTH PART 2

Cultural and Health Needs and Interests (Cont.)

Indicate how likely you would be to participate in and/or complete each of the following program categories if they were offered by your company's worksite wellness program during the next year.

NOTE: Fill in one bubble per row for each question.

	Unlikely	Somewhat	Neutral	Likely	Extremely
Nutrition	◯	◯	◯	◯	◯
Weight Management	◯	◯	◯	◯	◯
Back Care/Ergonomics	◯	◯	◯	◯	◯
Heart Health	◯	◯	◯	◯	◯
Self-Care	◯	◯	◯	◯	◯
Stress/Depression Management	◯	◯	◯	◯	◯
Physical Fitness/Exercise	◯	◯	◯	◯	◯
Smoking Cessation	◯	◯	◯	◯	◯
Biometric Screening Services	◯	◯	◯	◯	◯

Worksite Wellness Programs and Services

I would be more likely to participate in Worksite Wellness Programs if they were offered:

NOTE: Fill in one bubble per row for each question.

	Unlikely	Somewhat	Neutral	Likely	Extremely
Before Work	◯	◯	◯	◯	◯
During Work (e.g., Lunch and Learns)	◯	◯	◯	◯	◯
After Work	◯	◯	◯	◯	◯