

2009 Springdale Health Department Survey

Please check if you have any of the following illnesses (Check all that apply):

- Asthma, or other lung disease
- Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- Mental Illness
- Other _____

Do you have a doctor?

- Yes No

Do you have a dentist?

- Yes No

Do you have health care insurance?

- Yes No

Is your blood pressure normal?

- Yes No I don't know

Is your blood glucose (sugar) is normal?

- Yes No I don't know

Are your cholesterol and lipid numbers normal?

- Yes No I don't know

Do you use a "week-long pill box system" to help you remember to take your medications?

- Yes No

Do you smoke or use tobacco products?

- Yes No

If yes, are you interested in quitting?

- Yes No

Do you want more information about quitting?

- Yes No

Do you eat at least 5 servings of fruits and/or vegetables each day?

- Most of the time Hardly ever

Do you eat low fat dairy products and lean meats?

- Most of the time Hardly ever

Are you overweight?

- Yes No

In the past year, have you participated in a group exercise program?

- Yes No

Check the average number of days per week that you exercise for 30 minutes:

- 1 2 3 4
- 5 6 7

If you are female, do you drink more than one alcoholic beverage per day?

- Yes No

If you are male, do you drink more than 2 alcoholic drinks per day?

- Yes No

Do you feel moderately happy on most days of the week?

- Yes No

If No, are you receiving counseling or treatment?

- Yes No

Do you always wear your seat belt?

- Yes No

Did you get a yearly flu shot this past fall/winter?

- Yes No

Are your children up to date with their immunizations (shots)?

- Yes No I don't know
- I do not have children

Based on your health history and age, do you know how often you should have the following?

Health Exam by a doctor

- Yes No

Dental Exam

- Yes No

Eye Exam

- Yes No

Hearing test

- Yes No

Cardiovascular tests (EKG/Stress test)

- Yes No

Thyroid Function test

- Yes No

Colonoscopy

- Yes No

Bone Density test

- Yes No

Skin Cancer Exam

- Yes No

STD tests

- Yes No

Mammogram

- Yes No Does not apply

Pap smear test

- Yes No Does not apply

Prostate exam

- Yes No Does not apply

PSA blood test?

- Yes No Does not apply

Have you called or visited the Health Department in the last year?

- Yes No

If yes, were you satisfied?

- Yes No

Thank you for completing and returning this survey!

My Gender:

- Male
- Female

My Age:

- Under 18
- 18 - 24
- 25 - 34
- 35 - 44
- 45 - 64
- 65 - 74
- 75 or older

My Race:

- Black/ African American
- Hispanic
- Multi-Racial
- White/Non-Hispanic
- Other