

Tri-County Adult Mental & Physical Health Survey

Date of Screening _____

Name _____

Age _____ Gender Male Female Other

Height _____ Weight _____ BMI _____ Waist Circumference _____

Blood Pressure _____ Pulse _____ Recent Blood Sugar _____

1. Do you have a Primary Care Physician? (Check one):

Yes No

If you answered yes, please provide your doctor's name:

2. How many times a year do you see your Primary Care Physician? (Check one)

None One Two Three Four or more

3. During the last month, how much have your personal or emotional problems interfered with your usual activities with friends, relatives, and neighbors? (Check one)

Not at all Very little Somewhat

Quite a lot All the time

4. During the last month, how often did you feel nervous or anxious? (Check one)

Not at all Very little Somewhat

Quite a lot All the time

5. During the last month, how often did you feel fearful or worried? (Check one)

Not at all Very little Somewhat

Quite a lot All the time

6. During the last month, how often did you feel stressed or overwhelmed? (Check one)

Not at all Very little Somewhat

Quite a lot All the time

7. During the last month, how often did you feel depressed or sad? (Check one)

Not at all Very little Somewhat

Quite a lot All the time

8. During the last month, how would you rate your sleep quality overall? (Check one)

Very bad Fairly bad Average

Fairly good Very good

9. During the last month, how was your appetite? (Check one)

Very bad Fairly bad Average

Fairly good Very good

10. Do you smoke cigarettes? (Check one) Yes No

11. Thinking of an average day this past month, how many servings of alcohol did you have in a typical day? One serving is a can of beer, glass of wine, or a shot of hard liquor. (Check one)

None 1-2 servings 3-4 servings

5-6 servings 7 or more servings

12. In general, how is your overall physical health? (Check one)

Excellent Very good Good Fair Poor

13. Compared to one year ago, how would you rate your health in general? (Check one)

Much better now than a year ago

Somewhat better now than a year ago

About the same as one year ago

Somewhat worse now than one year ago

Much worse now than one year ago

14. During the last month, how has your physical health interfered with your usual activities, like visiting friends/relatives, walking, climbing stairs, cleaning? (Check one)

Not at all Very little Somewhat

Quite a lot All the time

15. During the last month, how often did you lift or carry your own groceries? (Check one)

Not at all Very little Somewhat

Quite a lot All the time

16. During the last month, how often did you climb flights of stairs? (Check one)

Not at all Very little Somewhat

Quite a lot All the time

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17. During the last month, how often did you have difficulty bending or kneeling? (Check one)

- Not at all Very little Somewhat
 Quite a lot All the time

18. During the last month, how often did you have difficulty walking from place to place? (Check one)

- Not at all Very little Somewhat
 Quite a lot All the time

19. Within the last month, have you experienced any of the following? (Check all that apply)

- Frequent urination Excessive thirst
 Extreme hunger Unusual weight loss
 Increased fatigue Irritability
 Blurry vision

20. Do you have family members with diabetes? (Check one):

- Yes No

21. Have you recently had labs (blood work) done? (Check one)

- Yes No

22. Do you currently take any of the following medication listed? (Check all that apply)

- Clozapine/Clozaril Olanzapine/Zyprexa
 Quetiapine/Seroquel Asenapine/Saphris
 Risperidone/Risperdal Sulpiride/Meresal
 Amisulpride/Solian Remoxipride
 Aripiprazole/Abilify Perospirone/Lullan
 Melperone/Buronil LLoperidone/Fanapt
 Paliperidone/Invega Sertindole/Serdolect
 Ziprasidone/Geodon

23. Have you ever been told by your medical doctor or any other medical professional that you have any of the following? (Check all that apply)

- Heart Disease Heart Attack
 Stroke High Blood Pressure
 High Cholesterol Diabetes
 Asthma Arthritis
 Epilepsy Seizures
 Liver Disease Overweight
 HIV Underweight

If you **checked Diabetes** in question 23, please answer the following questions. If you **did not check Diabetes**, you are done with the survey.

24. How many times a year do you see a doctor for your Diabetes? (Check one)

- None One Two Three Four or more

25. Do you know what your last A1c level was? A1c level is blood work completed at a lab that provides information about your average glucose level over a three-month period. (Check one)

- Yes No

If you answered yes, what was your level: _____

26. If you are taking any medications listed in question 22, have you had a recent lipid done? Yes No

27. How many times throughout the day do you check your glucose level using your portable monitor? (Check one)

- None One Two Three Four or more

28. When was your last foot exam? (Check one)

- Never Within 3 months Within 6 months
 Within 12 months 12 months plus

29. When was your last eye exam? (Check one)

- Never Within 3 months Within 6 months
 Within 12 months 12 months plus