



MY HEALTH PROFILE

MyHealthProfile is designed to give you information about your health and help guide you in your efforts toward making healthy behavior changes. All of the information you provide on this survey will be kept strictly confidential and will only be used to provide you with information about your health risk factors and to invite you to join wellness programs. Our goal is to provide you with tools and information you need to make healthy lifestyle changes.

Learn more about YOUR health. It only takes about 20 minutes to complete this assessment. The information and tools provided to you once completed, however, can improve your health and quality of life for many years to come.

If you have any questions about MyHealthProfile, please contact Customer Care at 1-866-449-9705.

Healthways Consent Form

I consent to participate in Healthways' Health Risk Screening and Support Program (the "Program"), which may include drawing blood for laboratory testing, taking biometric measurements such as weight and blood pressure, and/or completing an on-line or written Health Risk Assessment. I understand that my participation in the Program is voluntary and that I am not required to participate as a condition of employment or of enrollment in my health plan.

In addition, I consent to Healthways providing me with a report (either on-line or in writing) of my wellness screening results and, if applicable, periodically providing me with follow-up educational materials and information relevant to my wellness screening results.

I understand that the Program is offered by my health plan or employer acting as the sponsor of my health plan. If my health plan implements an incentive program as part of the Program, I consent to Healthways informing my health plan or my employer acting as the sponsor of my health plan whether or not I qualify for such incentive based upon my participation in the Program. I understand that if I do not elect to provide such consent, I may not qualify for such incentive.

I understand that my health plan or employer acting as the sponsor of my health plan may from time to time offer enrollees other health and wellness services and programs (collectively, "Other Health/Wellness Programs"), such as employee assistance and disease management programs. I consent to the disclosure by Healthways of my wellness screening results and/or other personal health information that identifies me to Other Health/Wellness Program providers, so that they may contact me for the purpose of addressing my particular health/wellness needs. I understand that Healthways and/or my health plan or employer acting as the sponsor of my health plan will require such Other Health/Wellness Program providers to agree to maintain the confidentiality of any wellness screening results and/or other personal health information provided to them by Healthways. I understand that if I do not want Healthways to disclose my wellness screening results and/or other personal health information to Other Health/Wellness Program providers, I must notify Healthways in writing.

I understand that this consent will remain in effect for as long as I participate in the Program or such shorter period permitted by law. I may revoke this consent at any time by notifying Healthways in writing, to the extent Healthways has not already relied on this consent.

Any notice to Healthways should be sent to Healthways, 3841 Green Hills Village Drive, Nashville, TN 37215, Attn: MHIQ. I understand that I am entitled to a copy of this consent.

1

Name: PLEASE PRINT

Signature: PLEASE SIGN

MM / DD / YYYY date entry boxes

Date of Signature:

INSTRUCTIONS:

Use a pencil, black or blue pen. Fill response bubbles completely. Do **not** use X's or √'s to indicate your responses. Do **not** use red ink.

Correct Mark Incorrect Marks

Example

1	2
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

Name of Company

[Grid for Name of Company]

2 Receive Your Report Online

Yes, Online Report

The quickest way to receive your personal health report is online. Provide your email address to receive instant notification when your report is ready.

[Grid for Email Address]

EMAIL ADDRESS

FORMAL NAME & ADDRESS

[Grid for First Name]

FIRST NAME

[Grid for Middle Initial or Middle Name]

MIDDLE INITIAL or MIDDLE NAME

[Grid for Last Name]

LAST NAME

[Grid for Street Address]

STREET ADDRESS

[Grid for Apartment or Suite#]

APARTMENT OR SUITE#

[Grid for City]

CITY

[Grid for State]

STATE

[Grid for ZIP]

ZIP

DEMOGRAPHICS

Gender

Male Female

Date of Birth

[Grid for Date of Birth: MM/DD/YYYY]

You are:

- White
- Black
- Hispanic
- Asian
- Pacific Islander
- American Indian
- Other

What is your daytime telephone number?

Extension

[Grid for Telephone Number and Extension]

When is the best time to contact you?

Morning (8:00am - 11:59am EST) Afternoon (12:00pm - 4:30pm EST)



46230

SELF AWARENESS

16. Do you know what your total cholesterol number was the last time you had it tested?

- Yes, I know.
 No, I don't know.
 I've never had it tested.

16a. If yes, what was your total cholesterol number the last time it was tested?

17. Do you know what your LDL (bad) cholesterol number was the last time you had it tested?

- Yes, I know.
 No, I don't know.
 I've never had it tested.

17a. If yes, what was your LDL number the last time it was tested?

18. Do you know what your HDL (good) cholesterol was the last time you had it tested?

- Yes, I know.
 No, I don't know.
 I've never had it tested.

18a. If yes, what was your HDL number the last time it was tested?

19. Do you know what your blood pressure was the last time you had it checked?

- Yes, I know.
 No, I don't know.
 I've never had it tested.

19a. If yes, what was your systolic (upper number) blood pressure the last time you had it checked?

19b. If yes, what was your diastolic (lower number) blood pressure the last time you had it checked?

MEDICAL HISTORY

20. How tall are you?

 ft. in.

21. How much do you weigh (in pounds)?

22. Has a doctor told you that you have any of the following? (fill in ● all that apply)

- | | | |
|--|---|--|
| <input type="radio"/> Allergies | <input type="radio"/> Depression . . . (if Yes, also answer #22c) | <input type="radio"/> Liver disease |
| <input type="radio"/> Angina (chest pain) | <input type="radio"/> Diabetes (if Yes, also answer #22d) | <input type="radio"/> Migraines . . (if Yes, also answer #22f) |
| <input type="radio"/> Asthma (if Yes, also answer #22a) | <input type="radio"/> End stage renal disease | <input type="radio"/> Osteoporosis (weak bones) |
| <input type="radio"/> Back pain | <input type="radio"/> Frequent colds (3 or more a year) | <input type="radio"/> Past stroke |
| <input type="radio"/> Cancer (if Yes, also answer #22g) | <input type="radio"/> High cholesterol (fat in the blood) | <input type="radio"/> Prostate problems |
| <input type="radio"/> Chronic bronchitis, emphysema or COPD (lung problems) | <input type="radio"/> Hypertension . .(if Yes, also answer #22e) | <input type="radio"/> Thyroid problems |
| <input type="radio"/> Congestive heart failure (heart pump problems) | <input type="radio"/> Kidney disease | <input type="radio"/> Do not know |
| <input type="radio"/> Coronary artery disease (if Yes, also answer #22b) (heart problems or hardening of arteries) | | <input type="radio"/> None of these |

22a. My **asthma** is being treated successfully as recommended by my doctor.

- Yes No

22b. My **coronary artery disease** is being treated successfully as recommended by my doctor.

- Yes No

22c. My **depression** is being treated successfully as recommended by my doctor.

- Yes No

22d. My **diabetes** is being treated successfully as recommended by my doctor.

- Yes No

22e. My **hypertension** is being treated successfully as recommended by my doctor.

- Yes No

22f. My **migraines** are being treated successfully as recommended by my doctor.

- Yes No

22g. Are you currently being treated for **cancer** or any **cancer-related** complications?

- Yes No



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MEDICAL HISTORY

Answer this question ONLY if you answered that a doctor has told you that you have High Cholesterol

Consistently taking your cholesterol medication means: taking the entire dose you and your doctor agreed was right for you without forgetting, missing, skipping, or adjusting your dose; and contacting your doctor if you have questions, concerns, or are unsure about if you need to stay on the medication.

23. Do you consistently take cholesterol medication according to the previous definition?
- No, and I do not intend to in the next 6 months
 - No, but I intend to in the next 6 months
 - No, but I intend to in the next 30 days
 - Yes, I have been but for less than 6 months
 - Yes, I have been for 6 months to a year
 - Yes, I have been for more than 1 year
 - I have not been given a prescription for cholesterol-lowering medication

Answer this question ONLY if you answered that a doctor has told you that you have Hypertension

Consistently taking your blood pressure medication means: taking the entire dose you and your doctor agreed was right for you without forgetting, missing, skipping, or adjusting your dose; and contacting your doctor if you have questions, concerns, or are unsure about if you need to stay on the medication.

24. Do you consistently take blood pressure medication according to the previous definition?
- No, and I do not intend to in the next 6 months
 - No, but I intend to in the next 6 months
 - No, but I intend to in the next 30 days
 - Yes, I have been but for less than 6 months
 - Yes, I have been for 6 months to a year
 - Yes, I have been for more than 1 year
 - I have not been given a prescription for high blood pressure medication

25. In the past 12 months, how many times have you:

- a. Gone to the emergency room? 0 times 1-2 times 3-5 times 6 or more times
- b. Stayed overnight in a hospital? 0 times 1-2 times 3-5 times 6 or more times

26. Are you thinking about any of the following in the near future? (fill in ● all that apply)

- Joint replacement
- Heart surgery
- Other surgery
- Hysterectomy (removal of the uterus)
- Prostate surgery
- None of these
- Back surgery

PREVENTIVE HEALTH SERVICES

27. When was the last time you had a flu shot?

- Within the past 12 months
- Not sure
- More than 12 months ago
- Never had a flu shot

28. Have you been checked for colon cancer by a doctor (through stool test, blood test, scope, etc)?

- Yes
- Not applicable because I am 49 years of age or younger
- No

WOMEN'S HEALTH (For Women Only)

29. Are you pregnant?

- Yes (if Yes, go to question #29a and #29b)
- No (if No, go to question #30)

Answer questions 29a and 29b ONLY if you are pregnant

29a. How many months have you been pregnant?

- 1 to 3 months
- 7 to 9 months
- 4 to 6 months
- Not sure

29b. Are you under a doctor's care for your pregnancy?

- Yes
- No

30. Are you planning a pregnancy in the next 12 months?

- Yes
- No

31. Have you ever had a breast x-ray? (mammogram)

- Yes
- No
- Not applicable because I am 39 years of age or younger

32. How long has it been since you had your last Pap smear? (A Pap Smear is a test for cancer of the cervix.)

- Within the past 1 year
- 4 or more years ago
- Within the past 3 years
- I have never had a pap smear



EMOTIONAL HEALTH

Stress management includes regular relaxation, physical activity, talking with others, and/or making time for social activities.

33. Do you effectively practice stress management in your daily life?

- No, and I do not intend to in the next 6 months
- No, but I intend to in the next 6 months
- No, but I intend to in the next 30 days
- Yes, I have been, but for less than 6 months
- Yes, I have been for more than 6 months
- I currently do not have any stress in my life

34. In general, how satisfied are you with your life?

- Completely satisfied
- Mostly satisfied
- Partly satisfied
- Not satisfied

35. Over the last 2 weeks, how often have you been bothered by any of the following problems?

- a. Little interest or pleasure in doing things Not at all Several days More than half the days Nearly every day
- b. Feeling down, depressed, or hopeless Not at all Several days More than half the days Nearly every day

36. During the past 12 months, how many days did your feelings keep you from working all or most of the day?

- None
- 1 - 2 days
- 3 - 5 days
- 6 or more days

37. How often do you use drugs or medications (including prescriptions) which affect your mood or help you relax?

- Almost every day
- Sometimes
- Rarely or never

PHYSICAL HEALTH

38. During the past 12 months, how many days did being sick or injured keep you from working all or most of the day?

- None
- 1 - 2 days
- 3 - 5 days
- 6 or more days

39. Compared to others your age, how would you describe your overall health?

- Excellent
- Very good
- Good
- Fair
- Poor

WEIGHT MANAGEMENT

Healthy eating means doing both of the following:

- Eating the number of calories that allows you to reach and maintain a healthy weight
- Eating a diet that is low in fat

Eating the number of calories that allows you to reach and maintain a healthy weight means doing things like:

- Paying attention to serving sizes
- Telling yourself that every calorie counts
- Eating small portions
- Eating more vegetables and fruits
- Avoiding taking handfuls of unhealthy snacks

40. Do you eat the number of calories that allows you to reach and maintain a healthy weight? No Yes

Eating a low-fat diet means doing things like:

- Eating fruits and vegetables as snacks
- Eating chicken without the skin
- Eating bread without butter
- Eating low-fat cheeses and other low-fat dairy products
- Using light or fat-free salad dressing, or eating salad without dressing

41. Do you eat a diet that is low in fat? No Yes

Answer this question ONLY if you answered "No" to either 40 or 41

42. Are you planning to change what you eat so you can answer YES to the two previous questions?

- NO, and I do NOT intend to in the next 6 months
- YES, and I intend to in the next 6 months
- YES, and I intend to in the next 30 days

Answer this question ONLY if you answered "Yes" to BOTH 40 & 41

43. How long have you been doing these two things?

- For LESS than 6 months
- For MORE than 6 months

EXERCISE HABITS

Regular moderate exercise is any planned physical activity (e.g., fast walking, aerobics, jogging, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, dancing, etc.) performed to increase physical fitness. Exercise should be done at a level that increases your breathing rate and causes you to break a light sweat.

44. Do you engage in regular moderate exercise according to the previous definition **5-7 times per week** for at least **30 minutes**?
- No, and I do not intend to in the next 6 months
 - No, but I intend to in the next 6 months
 - No, but I intend to in the next 30 days
 - Yes, I have been, but for less than 6 months
 - Yes, I have been for more than 6 months

45. During the past month, other than your regular job, how often did you participate in any physical activity (exercise that was hard enough to make you breathe heavily and increase your heart rate and was done for at least 30 minutes)?

- Less than 1 time per week
- 1 - 2 times per week
- 3 times per week
- 4 times per week
- 5 or more times per week

TOBACCO USE

46. Have you ever smoked cigarettes? Yes (if Yes, go to question #47) No (if No, go to question #48)

47. Have you quit smoking cigarettes?

- No, and I do not intend to quit in the next 6 months
- No, but I intend to quit in the next 6 months
- No, but I intend to quit in the next 30 days
- Yes, I quit less than 6 months ago
- Yes, I quit more than 6 months ago

ALCOHOL AND SUBSTANCE USE

48. Do you drink alcohol? Yes (if Yes, go to question #48a) No (if No, go to question #49)

48a. If you answered "Yes", how many alcoholic drinks do you have in a typical week? (one drink is equal to one beer, one glass of wine, one shot of liquor, or one mixed drink)

- Rarely
- 0-4 drinks a week
- 5-9 drinks a week
- 10-13 drinks a week
- 14 or more drinks a week

49. Do you use or experiment with drugs? Yes (if Yes, go to question #50) No (if No, go to question #51)

Answer this question ONLY if you answered "Yes" to either 48 & 49

50. During the last three months: (fill in **●** all that apply)

- have you felt you should cut down or stop drinking or using drugs?
- has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?
- have you felt guilty or bad about how much you drink or use drugs?
- have you woken up wanting to have an alcoholic drink or use drugs?
- This question does not apply to me.

WORK AND FAMILY

51. Are you satisfied with your job?

- Completely satisfied
- Mostly satisfied
- Partly satisfied
- Not satisfied

SAFETY

52. What percentage of the time do you wear your seat belt when driving or riding in a vehicle?

- 100%
- 90 - 99%
- Less than 90%