

HEALTH RISK APPRAISAL

Date _____

Gender: male female

Name (print) _____

Social Security # _____

Local telephone _____

Date of Birth _____

Email Address: _____

It is the philosophy of the staff of Murray State University Health Services to provide you with the best care possible. To accomplish this, it is important for us to review significant health issues that might impact your health. Our health screening form is given to all students on their first visit to the health center. We will review the information with you today and from time to time as you come in for services. You may leave any question blank if you choose. **This appraisal form is a confidential document that will be kept in your medical record in the Health Service. No information may be released without your written consent, unless required by law.**

Please note that the answer boxes to be checked are not the same from question to question. Please read carefully and complete the information as accurately as possible.

Eating/Weight

1. Are you satisfied with your eating habits? No Yes
2. Do you ever eat in secret? Yes No
3. Do you spend a lot of time thinking about ways to be thin? Yes No
4. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself? Yes No
5. Do you eat at least five daily servings of fruit and vegetables? No Yes
6. Do you currently get at least 30 minutes of moderate intensity physical activity on most days of the week? No Yes
7. Have you ever had a cholesterol test? No Yes
Results: _____ Date: _____

School

8. Are your grades worse than last year? Yes No
9. Have you ever been told you have a learning problem or do you think you have a learning problem? Yes No

Weapons/Violence/Safety

10. Do you or anyone you live with have a gun, rifle, or other firearm? Yes No Not Sure
11. In the past year, have you carried a gun, knife, club, or other weapon for protection? Yes No
12. Have you been in a physical fight during the *past three months*? Yes No
13. Have you ever been charged with a violent crime? Yes No
14. Do you feel safe where you live? No Yes Not Sure
15. Have you ever been physically, sexually, or emotionally abused? Yes No Not Sure
16. Do you always wear a helmet when you rollerblade, skateboard, ride a bicycle, motorcycle, minibike, or ride in an all-terrain vehicle (ATV)? No Yes N/A
17. Do you always wear a seat belt when you ride in or drive a car/truck/van? No Yes
18. Are you living in a place with a smoke detector? No Yes Not Sure
19. Do you use a tanning bed or sunbathe frequently? Yes No

Tobacco

20. Do you ever smoke cigarette, cigars, use snuff or chew tobacco? Yes No
21. Does anyone you live with smoke cigarettes, cigars, use snuff or chew tobacco? Yes No

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Alcohol

22. In the past month, did you get drunk or very high on beer, wine, or other alcohol? Yes No
23. Have you ever been criticized or gotten into trouble because of drinking? Yes No
24. In the past year, have you had 2 or more drinks and then driven a car/truck/van/motorcycle? Yes No
25. In the past year, have you been in a car or other motor vehicle when the driver has had two or more drinks or used drugs? Yes No
26. Do you have a family history of alcohol abuse? Yes No

Drugs

27. Have you used narcotics, stimulants, cocaine, LSD, or other street drugs more than once in the past six months? Yes No
28. Do you use marijuana? Yes No
29. Do you frequently use tranquilizers or sleeping pills? Yes No
30. Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high? (These drugs can be bought at a store without a Dr's prescription.) Yes No
31. Have you ever used steroid pills or shots without a doctor telling you to? Yes No
32. Have you ever started yourself on leftover antibiotics or someone else's antibiotic for a cold, sore throat, etc.? Yes No

Development

33. Do you have any concerns or questions about the size or shape of your body or your physical appearance? Yes No
34. Do you have any concerns about your sexual identity? Yes No
35. Have you ever been sexually active? (i.e. any genital contact with another person) Yes No
36. Are you currently sexually active? Yes No
37. Have your sexual partners been? Men Women Both
38. Have you ever had a pap smear? No Yes N/A
If yes, when? _____ Result? _____
39. Are you using a method to prevent pregnancy? No Yes N/A
If yes, what? _____
40. Did you use safer sex practices (condom, dental dam (latex square, etc.) during your last sexual activity? No Yes Not active
41. Have you practiced safer sex: with your current partner(s)? Never Sometimes Always
with your past partner(s)? Never Sometimes Always
42. Do you know the past sexual history of your partner(s)? No Yes Not active
43. Have you ever been told by a doctor or nurse that you had a sexually transmitted infection or disease? Yes No
44. Have you ever been pregnant or gotten someone pregnant? Yes No
45. Are you aware that emergency contraception ("the morning after pill") is available for women? No Yes
46. Would you like to receive information or supplies to prevent –
a. pregnancy? Yes No
b. sexually transmitted infections? Yes No
47. Would you like to know how to avoid getting the HIV/AIDS infection? Yes No
48. Do you do breast self-exam or testicular self-exam regularly? No Yes
49. Have you ever pierced your body (not including ears) or gotten a tattoo? Yes No Thinking about it
50. Have you been to your dentist for a check-up during the past year? No Yes
51. Have you had your vision checked during the past two years? No Yes
52. Do you know whether you are up-to-date on your immunizations? No Yes

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Emotions

- 53. Have you had fun during the past two weeks? No Yes
- 54. During the past few weeks, have you *often* felt sad or down or as though you have nothing to look forward to? Yes No
- 55. Have you ever seriously thought about killing yourself, made a plan or actually tried to kill yourself? Yes No
- 56. When you get angry, do you do violent things? Yes No
- 57. Would you like to talk to someone about something you have on your mind? Yes No
- 58. Would you want someone to contact you with information about mental health services on campus? Yes No

Self

59. What do you perceive to be your health and wellness needs at this time?

60. Do you have any other concerns?

Yes _____ No

60. Would you be interested in receiving wellness-related emails? Yes No

Nurse's Signature _____ Date _____

Brochures Given: _____

Referred to Health Educator: Yes No

Date of Nurse/Patient Review _____
