**SEVAK: HEALTH, DISEASE AND NUTRITIONAL SURVEY**

I. **Demographics:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE \_\_\_\_\_

M/D/YR

I. **Sex**: Female \_\_\_\_\_\_ Male \_\_\_\_\_

*2.* **Marital Status***:*

a. Married

d. Divorced

c. Widowed

d. Separated

e. Never been married

3. **Income level:**

*Are you currently:*

1. Employed for wages
2. Self-employed
3. Out of work
4. Homemaker

e. Student

f. Retired

g. Unable to work

4. **Educational level**:

*What is the highest grade or year of school you completed?*

1. Grades 1 through 8 (Elementary)
2. Grades 9 through 11 (Some high school)
3. Grades 12 or GED (High school graduate)
4. College 1 year to 3 years (Some college or technical school)
5. College 4 years or more (College graduate)
6. Post graduate
7. No formal education

**II. Personal History**:

1. Allergies:

2. Smoking

1. Everyday
2. Some days
3. Not at all

Do you use:

Chewing tobacco \_\_\_\_\_ Cigarettes \_\_\_\_\_\_ Cigars \_\_\_\_\_\_Smokeless tobacco \_\_\_

(Checking all that apply)

On average, about how may cigarettes/chewing tobacco/smokeless tobacco a day do you now use? Number \_\_\_\_\_\_

5. **Drinking Alcohol**:

Considering all types of alcoholic beverages, how many times during the past month did you have 5 or more drinks on occasion?

\_\_\_None \_\_\_\_Once \_\_\_Twice \_\_\_\_3to5 times \_\_\_\_6 to 9 times \_\_\_10 or more times

6**. Diet**:

Do you have any Dietary Restriction (medical)? No \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_

(If Yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

7**. Drug Abuse**:

**III. FAMILY HISTORY:**

FATHER: Alive Deceased *(if deceased)* AGE AT DEATH\_\_\_\_ REASON

MOTHER: Alive Deceased *(if deceased)* AGE AT DEATH\_\_\_\_ REASON

Do you have any family history of illness of any of the following (please do not include spouse and his/her family members)?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** | **Brother** | **Sister** | **Father** | **Mother** | **(Grand parents/ Uncles, aunts, etc)** |
| **Diabetes** |  |  |  |  |  |
| **Heart attacks before age 50** |  |  |  |  |  |
| **High blood pressure** |  |  |  |  |  |
| **Stroke** |  |  |  |  |  |
| **Kidney dialysis** |  |  |  |  |  |
| **Cancer (please specify what kind)** |  |  |  |  |  |
| **Jaundice** |  |  |  |  |  |
| **Arthritis** |  |  |  |  |  |
| **High Blood Cholesterol** |  |  |  |  |  |
| **Depression** |  |  |  |  |  |

**IV. MEDICAL HISTORY:**

1. Did a doctor or a nurse ever examine you for any of the following conditions? Please answer yes or no. (Read the choices)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **YES** | **NO** | **Never Heard of Disease** | **Don’t know/Not sure** | **Refused** |
| **High Blood Cholesterol (fatty substance in blood)** |  |  |  |  |  |
| **Breast Cancer** |  |  |  |  |  |
| **Cervical Cancer** |  |  |  |  |  |
| **Colo-rectal Cancer** |  |  |  |  |  |
|  | **YES** | **NO** | **Never Heard of Disease** | **Don’t know/Not sure** | **Refused** |
| **Prostate Cancer** |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |
| **Heart Disease** |  |  |  |  |  |
| **High Blood Pressure** |  |  |  |  |  |
| **Depression** |  |  |  |  |  |
| **Arthritis** |  |  |  |  |  |
| **Tubeculosis** |  |  |  |  |  |
| **Kidney problems** |  |  |  |  |  |
| **Thyroid problems** |  |  |  |  |  |
| **Back problems** |  |  |  |  |  |

**Diabetes Questions:**

1. **Have you ever been told by a doctor that you have diabetes?**

a. Yes b. No

**(If female) Told only during pregnancy?** a. Yes b. No

1. **How old were you when you were told you have diabetes? Years of age when you were told \_\_\_\_\_\_\_\_\_.**
2. **Are you now taking insulin?** a. Yes b. No
3. **Are you taking diabetes pills?** a. Yes b. No
4. **About how often do you check your blood for glucose or sugar? Include times when checked by a family member or friend, but do not include times when checked by a health professional:**

a. Times per day

b. Times per week

c. Times per month

d. Times per year

e. Never

1. **About how often do you check your feet for any sores or irritations? Include times when checked by a family member or friend, but do not include times when checked by a health professional.**

a. Times per day

b. Times per week

c. Times per month

d. Times per year

e. Never

f. I have no feet

1. **Have you ever had any sores or irritations on your feet that took more than four weeks to heal?**

a. Yes b. No

1. **About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes?**

a. Number of times \_\_\_\_\_\_\_\_ b. None

1. **A test for hemoglobin “HbA1c” measures the average level of blood sugar over the past three months. About how many times in the past 12 months has a doctor, nurse or other health processional checked you for hemoglobin “A one C”?**

a. Number of times \_\_\_\_\_\_\_\_

b. None

c. Never heard of hemoglobin “HbA1c” test

1. **About how many times in the past 12 months has a health professional checked your feet for any sores or irritation?**

a. Number of times \_\_\_\_\_\_\_\_ b. None

1. **When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light.**

a. Within the past month (0-1 month ago)

b. Within the past year (1-12 months ago)

c. Within the past 2 years (1 to 2 years ago)

d. 2 years ago

e. Never

1. **Has a doctor ever told you that diabetes has affected your eyes or that you had retinopathy?**

a. Yes b. No

1. **Have you ever taken a course or class in how to manage your diabetes yourself?**

a. Yes b. No

**Blood Pressure**

1. **About how long has it been since you last had your blood pressure taken by a doctor, nurse, or other health professional?**

a. Within the past 6 months (1 to 6 months ago) b. Within the past years (6-12 months ago)

c. Within the past 2 years (1 to 2 years ago) d. Within the past 5 years (2 to 5 years ago)

e. 5 or more years ago

1. **Have you ever been told by a doctor, nurse of other health professional that you have high blood pressure?**

a. Yes

b. No 🡪 In No, skip to question 4.

1. **Have you been told on more than one occasion that your blood pressure was high, or have you been told this only once?**

a. More than once

b. Only once

1. **Blood cholesterol is a fatty substance found in blood. Have you ever had your blood cholesterol checked?**

a. Yes \_\_\_\_Your cholesterol level is \_\_\_\_\_\_\_\_\_\_\_\_

b. No

1. **About how long has it been since you last had your blood cholesterol checked?**

a. Within the past year (1 to 12 months ago

b. Within the past 2 years (1 to 2 years ago)

c. Within the past 5 years (2 to 5 years)

**Cancer:**

1. Do you know how to do breast examination to check for a mass? Yes\_\_\_\_How often\_\_\_No\_\_\_\_\_
2. Have you had a PAP smear? Yes\_\_\_\_When\_\_\_\_\_

No\_\_\_\_\_\_\_\_

1. Do you smoke? Yes\_\_\_\_\_\_No\_\_\_\_\_\_\_
2. Do you know you can get lung and other cancers from smoking? Yes\_\_\_\_\_\_\_No\_\_\_\_\_\_\_
3. Do you chew tobacco? Yes\_\_\_\_\_No\_\_\_\_\_
4. Do you know you can mouth cancer from chewing tobacco and or smoking?

**MEASUREMENTS**

HEIGHT: \_\_\_\_FT \_\_\_\_\_IN : WEIGHT: \_\_\_\_\_\_ LBS : B.M.I:

WAIST CIRCUMFERENCE: \_\_\_\_ IN : HIP CIRCUMFRENCE\_\_\_\_\_IN : BLOOD PRESSURE: \_\_\_\_\_\_\_\_

FBS (fasting blood sugar):\_\_\_\_\_\_\_mg%

**VI. DIAGNOSIS:**

**VII. FOLLOW UP AND COMMENTS:**

**SIGNATURE**: