Marathon Health Questionnaire

Personal Information

Name: (First)_______________________(M)_______________(Last) _

Date:___________________Email: _____________________________

Best number to reach you:___________________ ☐ Home ☐ Work ☐ Cell (mobile)

Do you have a primary care provider? ☐ No ☐ Yes, name:____________________Ph _______________

I. Personal/Demographics

1. Date of Birth:_________(mm/dd/yyyy)

2. Gender:
- ☐ Female
- ☐ Male
- ☐ Other

II. General Health and Wellbeing

1. In general, would you say your health is:
- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

2. In general, are you satisfied with your life?
- ☐ Yes
- ☐ No
- ☐ Partly

3. What is the current level of stress in your personal life (social, family, financial, health, etc.):
- ☐ Low
- ☐ Medium
- ☐ High

4. What is the current level of stress in your work life (includes volunteer and work in the home):
- ☐ Low
- ☐ Medium
- ☐ High

5. During the past year, how much impact has stress had on your health or wellbeing (for example, frequent illnesses, back or other pain, always tired due to poor/lack of sleep, etc.)?
- ☐ A lot of impact on my health
- ☐ Some impact on my health
- ☐ Hardly any impact on my health
- ☐ No impact on my health

6. Do you feel that you cope well with stress?
- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ No, rarely cope well with stress

7. Would you like more information about stress management?

☐ Yes ☐ No

8. The overall quality of my sleep (select any that apply):
- ☐ I have difficulty falling asleep or staying asleep
- ☐ I have restless sleep
- ☐ I easily doze off/fall asleep during most days
- ☐ I have been told or know that I snore
- ☐ I have no issues with the quality of my sleep

9. On average, I get:
- ☐ 7 to 8 or more hours of sleep a night
- ☐ 6 hours of sleep a night
- ☐ 5 hours or less of sleep a night

Marathon health
For life.

An **advance directive** is a legal way to state your wishes at the end of your life. It tells your family and your doctor what to do if you can no longer say what you want.

10. Do you have a living will for healthcare decisions?

☐ Yes ☐ No

11. Have you appointed a healthcare proxy for healthcare decisions?

☐ Yes ☐ No

12. Would you like more information about advance directives (for example, living wills, healthcare proxy)?

☐ Yes ☐ No

III. Health History - Symptoms

1. Have you experienced any of the following symptoms within the last 3-6 months? Select all that apply or "None of these symptoms apply to me."

- ☐ Weight loss (unintended)
- ☐ Weightgain of 10pounds ormore in the past year
- ☐ Fatique
- ☐ New skin mole
- ☐ Tendencyto bruise easily
- ☐ Chest pain, discomfort, or pressure (if urgent, seek immediatecareorcall911)
- ☐ Palpitations (pounding, racing, or irregular heartbeat)(if urgent, seek immediate care or call 911)
- ☐ Wheezing
- ☐ Shortnessofbreathatrest
- ☐ Shortness of breath with physical activity
- ☐ Frequent need to urinate
- ☐ Dizziness
- ☐ Depressedmood
- ☐ Death of a family member or close friend
- ☐ None of these symptoms apply to me

IV. Medical Health History

1. Has a healthcare provider informed you that you have any of the following health problems (currently or in the past?) Select all that apply or "No known medical issues."

- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Hypertension (high bood pressure)
- ☐ Stroke
- ☐ Heart attack
- ☐ Heart failure
- ☐ Angina pectoris
- ☐ Coronary artery disease
- ☐ Colonpolyps
- ☐ Diabetes (type 1 ortype 2)
- ☐ High cholesterol
- ☐ Osteoarthritis
- ☐ Attention deficit hyperactivity disorder
- ☐ Depressivedisorder(majordepression,bipolar disorder, or dysthymia)
- ☐ No known medical issues

V. Medication & Supplements

1. Are you taking any prescription medications?

☐ Yes ☐ No

2. Are you taking any over-the-counter medications?

☐ Yes ☐ No

3. Would you like to know more about dietary supplements (for example, megavitamins, protein drinks, herbal products)?

☐ Yes ☐ No

4. Do you have any medication allergies?

☐ Yes ☐ No

VI. Eating Habits and Nutrition

1. Do you eat healthy meals and snacks most of the time?

☐ Yes ☐ No

2. What is the average number of fast food meals that you eat or take out per week?

- ☐ None to once a week
- ☐ 2 to 3 times a week
- ☐ 4ormoretimesaweek

3. On average, how many servings of fruits and vegetables do you eat each day (one serving is 1 cup fresh, 1/2 cup cooked, or 1 medium size fruit)?

- ☐ 6 or more servings
- ☐ 4 to 5 servings
- ☐ 2 to 3 servings
- ☐ None to 1 serving

4. Do you limit the amount of fat you eat (for example, fried foods, fatty meats, whole milk, cheese, baked goods)?

☐ Yes ☐ No

5. On average, how many 8 oz. glasses of water do you drink each day?

- ☐ None
- ☐ 1 to 2
- ☐ 3 to 5
- ☐ 6ormore

6. On average, how many soda and sugary beverages (8-12 oz. per serving) do you drink each day?

- ☐ One or less
- ☐ 2 to 4
- ☐ 5ormore

7. Nutrition and weight concerns - check all that apply:

- ☐ Iwouldlikeinformationaboutweightloss
- ☐ I am overweight and trying to lose weight
- ☐ I would like information about improving my nutrition
- ☐ I have other nutrition and diet issues I want to discuss
- ☐ Iwouldlikeinformationonthesaltcontentoffood
- ☐ I would like information about caffeine

VII. Exercise and Physical Activity

1. In a typical week, on how many days do you do moderate activities (causes small increases in breathing or heart rate) for at least 30 minutes such as brisk walking, bicycling at a regular pace, gardening, etc.?

- ☐ 1-2 days
- ☐ 3 days
- ☐ 4-5 days
- ☐ 6-7 days
- ☐ I don't typically do any moderate exercise

2. In a typical week, on how many days do you do any vigorous activities for at least 20 minutes such as running, cross country skiing, aerobics, fast bicycling, heavy lifting, etc.?

- ☐ 1-2 days
- ☐ 3 days
- ☐ 4-5 days
- ☐ 6-7 days
- ☐ I don't typically do any vigorous exercise

3. Other exercise information - check all that apply

- ☐ I would like to start an exercise program
- ☐ I would like to know more about aerobic exercising
- ☐ Iwouldlikeinformationaboutincreasingphysical activity
- ☐ I have other activity or exercise issues I want to discuss

VIII. Employment

1. Current employment status:

- ☐ I am employed or volunteer outside of the home
- ☐ I have no regular paid or volunteer work
- ☐ Iamretired

2. Are you satisfied with your current job?

- ☐ Yes
- ☐ No
- ☐ Partly
- ☐ Not employed outside of the household

3. During the past three months, how often have you had trouble at work concentrating or doing your best because of stressors or personal reasons in your life?

☐ Not at all
☐ Sometimes
☐ A lot/frequently
☐ Not applicable as I have no regular paid or volunteer work

4. How many days have you missed from work or regular activity due to illness in the last year?

☐ None or not applicable
☐ 1 to 2 days
☐ 3 to 4 days
☐ 5 or more days

5. Personal reasons, stressors, and other physical factors can have an impact on your job and/or daily performance. On a scale from 1 to 10, where 0 is the worst performance and 10 is a top performer, how would you rate your overall job and/or daily performance in the last 3 months?

____

IX. Substance Use

Tobacco Use:

1. Have you ever used tobacco products at any time in the past or currently?

☐ Yes ☐ No

***If no, please skip ahead to question #12.**

2. Do you smoke tobacco (cigarettes, cigars, pipes, light cigarettes)?

☐ Yes ☐ No

3. Do you smoke tobacco, but only under certain circumstances (e.g. social occasions)?

☐ Yes ☐ No

4. If you currently or have smoked in the past, on average, how many per day? _________

5. And for how many years? _________

6. Did you quit smoking less than a year ago?

☐ Yes ☐ No ☐ Not applicable

7. Years since stopped smoking tobacco: _______

8. Do you use smokeless tobacco (such as e-cigarettes, chewing tobacco, snuff)?

☐ Yes ☐ No

9. Did you quit using smokeless tobacco less than a year ago?

☐ Yes
☐ No
☐ Not applicable

10. Years since stopped using smokeless tobacco:

____

11. Would you like to stop or have more information on quitting smoking or using smokeless tobacco?

☐ Yes ☐ No

Alcohol Use:

12. How often did you have a drink containing alcohol in the past year?

☐ Never
☐ Monthly or less
☐ 2 to 4 times a month
☐ 2 to 3 times a week
☐ 4 or more times a week

***If never, please skip ahead to Safety and Exposures Section**

13. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

☐ 1 to 2 drinks
☐ 3 to 4 drinks
☐ 5 to 6 drinks
☐ 7 to 9 drinks
☐ 10 or more drinks

14. How often did you have 6 or more drinks containing alcohol on one occasion in the past year?

- ☐ Never
- ☐ Lessthanonce amonth
- ☐ Monthly
- ☐ Weekly
- ☐ Daily

15. General thoughts about alcohol - check any that apply:

- ☐ HavefeltIshouldcutbackonmydrinking
- ☐ Have been annoyed when people criticize my drinking
- ☐ Havefeltguiltyabout my drinking
- ☐ Have used alcohol first thing in the morning to steady my nerves or get rid of a hangover (eye-opener)
- ☐ Noneoftheseapplytome

16. Would you like more information on alcohol use or reducing alcohol intake?

☐ Yes ☐ No

X. Safety and Exposures

1. How often do you wear a seatbelt in a motor vehicle?

- ☐ Always
- ☐ Sometimes
- ☐ Never

2. In the past 6 months, how often did you drive after drinking alcohol or taking drugs?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

3. In the past 6 months, how often did you ride with drivers who have been drinking or using drugs?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

4. When in the sun, do you protect your skin by using a sunscreen at SPF 15 or higher and/or wear adequate/protective clothing?

- ☐ Allofthetime
- ☐ Mostofthetime
- ☐ Some of the time
- ☐ Rarely or never

5. How often do you (or your partner) use a condom when having sex?

- ☐ Always
- ☐ Sometimes
- ☐ Rarely or never
- ☐ Not applicable due to in a monogamous, long-term relationship or do not/have not had sex

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