Welcome to your Health Assessment

Welcome to the Health Assessment by MDVIP.

This Health Assessment is going to help me with your annual wellness program. It contains questions on many areas of health including diet, exercise and emotional well-being. Please complete the assessment and bring it to your wellness appointment.
MDVIP HEALTH ASSESSMENT

About You

What is your date of birth?

What is your gender?
Please check the appropriate box.

What is your height?
Please write your height in feet and inches.

What is your current weight?
Please write your current weight in pounds. Please note: If you are female and pregnant, enter your pre-pregnancy weight.

What is your waist circumference?
Enter the waist measurement of the most recent pair of pants that you have bought. If you don’t know your waist circumference, you can leave this blank.
MDVIP HEALTH ASSESSMENT

About You

How would you best describe your race and ethnic group?

We’d like to know about your racial and ethnic origins. The reason for this is that some diseases and illnesses are more common in people with certain backgrounds. Please check ONE answer only.

**WHITE**
- □ White American
- □ Other White Background

**SPANISH, HISPANIC OR LATINO**
- □ Mexican, Mexican American, Chicano
- □ Puerto Rican
- □ Cuban
- □ Other Spanish, Hispanic or Latino origin

**BLACK OR AFRICAN AMERICAN**
- □ African
- □ Caribbean
- □ Other Black Background

**ASIAN OR ASIAN AMERICAN**
- □ Asian Indian
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Vietnamese
- □ Other Asian Background

**OTHER ETHNIC / RACIAL GROUP**
- □ American Indian
- □ Alaska Native
- □ Native Hawaiian
- □ Guamanian or Chamorro
- □ Samoan
- □ Other Ethnic / Racial Group

**MIXED RACE**
- □ White and Black / African American
- □ White and Hispanic / Latino
- □ White and Asian
- □ Black / African American and Asian
- □ Black / African American and Hispanic / Latino
- □ Asian and Hispanic / Latino
- □ Other Mixed Background
- □ I prefer not to answer this
## Your Physical Activity

**Think about a typical 7-day week. How much of the following exercise do you get?**

Please write the number of days of exercise and the average time (in minutes) spent exercising.

<table>
<thead>
<tr>
<th>Exercise Type</th>
<th>Number of days</th>
<th>Average time each day (mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vigorous physical activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Like heavy lifting, digging, aerobics or fast cycling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate physical activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Like carrying light loads, cycling at regular pace or doubles tennis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking for at least 10 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes walking at work, home or for any exercise or leisure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MDVIP HEALTH ASSESSMENT

Your Tobacco Usage

Do you smoke or use chewing tobacco?

Please check ONE answer only.

- ☐ Yes, I currently smoke
- ☐ No, I gave up less than 10 years ago
- ☐ No, I gave up more than 10 years ago
- ☐ No, I’ve never smoked or chewed tobacco *(if you select this answer, skip the next question)*

Which of the following tobacco products do you/did you use?
Check the options below.

Please write how much tobacco you used or currently use and how long you have used it.

Cigarettes

In a single day, how many cigarettes do you/did you smoke?

How many years have you smoked?

Cigars

In a single day, how many cigars do you/did you smoke?

How many years have you smoked?

Pipes

In a single day, how many ounces of tobacco do you/did you smoke?

How many years have you smoked?

Chewing Tobacco

In a single day, how many ounces of chew or dip do you/did you use?

How many years have you smoked?
Your Drinking Habits

How many of the following non-alcoholic drinks do you usually consume in a typical day?
Please write the number of each type of drink you consume in the boxes below.

Coffee  
Tea  
Soda  
Diet Soda  
Energy Drink  
Water  
Milk  
Milk Shake  
Juice  
Hot Chocolate
Your Drinking Habits

Do you drink alcohol?
Please check ONE answer only.

☐ Yes
☐ No (if you select this answer, skip the next question)
☐ Only very occasionally, less than one drink a week (if you select this answer, skip the next question)

Add up the total number of alcoholic drinks you consume in an average week.
Please write the number of each type of drink you consume in the boxes below.

- Beer (12oz)
- White Wine (5oz)
- Red Wine (5oz)
- Malt Liquor (8oz)
- Shot of Spirits (1.5oz)
- Wine Cooler (12oz)
- Mixed Drinks (1.5oz)
- Cocktails (1.5oz)
MDVIP HEALTH ASSESSMENT

Your Eating Habits

When choosing foods, do you tend to eat high-fat or low-fat items?

Mark an ‘X’ along the line that best indicates your answer.

Some examples of low-fat foods:
• Salad, fruits and vegetables
• Pasta and rice
• Wholegrain breakfast cereals
• Bread
• Lean meat
• Fish
• Eggs
• Low-fat dairy products (incl. skimmed and semi-skimmed milk)
• Low-fat spread

Some examples of high-fat foods:
• Most carry-out and fast foods (pizza, curry, Chinese)
• Ready meals
• Fried foods (incl. fried breakfast)
• Crisps and chips
• Cakes, muffins and biscuits
• Donuts
• Pasties, pies and sausage rolls
• Sausages and burgers
• Hard cheese, butter and mayo
• Regular milk and milk shakes
• Chocolate bars
MDVIP HEALTH ASSESSMENT

Your Eating Habits

When choosing foods, do you tend to eat high-fiber or low-fiber items?

Mark an ‘X’ along the line that best indicates your answer.

Some examples of high-fiber foods:

• Wholegrain and brown bread
• Brown pasta and rice
• Nuts, lentils and beans
• Most fruits and vegetables
• Oats
• Wholegrain breakfast cereals (Shredded Wheat, Fruit and Fiber)
• Jacket potatoes

Some examples of low-fiber foods:

• White bread
• White pasta, rice and noodles
• Some breakfast cereals (Corn Flakes, Rice Krispies and CoCo Pops)
• Chips and crisps
• Potatoes without the skin
• Ready and microwave meals
MDVIP HEALTH ASSESSMENT

Your Eating Habits

When choosing foods, do you tend to eat high-salt or low-salt items?

Mark an ‘X’ along the line that best indicates your answer.

Some examples of low-salt foods:
- Fruits and vegetables
- Grilled chicken
- Grilled fish
- Plain pasta
- Unsalted nuts
- Eggs
- Mozzarella and most soft cheeses

Some examples of high-salt foods:
- Most ready and microwave meals
- Cured, smoked and preserved cold meats
- Many canned soups and foods
- Many carry-out and fast foods (pizza, Chinese, burgers)
- Chips and crisps
- Corn flakes
- Shop-bought bakery products
- White bread
- Ketchup
- Creamy sauces in restaurants
MDVIP HEALTH ASSESSMENT

Your Eating Habits

How often do you eat sweet, sugary foods in a typical day?

Please check ONE answer only.

- □ 5 times a day or more
- □ 4 times a day
- □ 3 times a day
- □ Twice a day
- □ Once a day
- □ Less than once a day, or never

On a typical day how many servings of fruits and vegetables do you eat?

Please check ONE answer only.

- □ None
- □ 1
- □ 2
- □ 3
- □ 4
- □ 5
- □ 6
- □ 7 or more
Your Medical Health

Which of the following medical conditions have you been diagnosed with?

Please check all of the conditions that apply to you.

☐ Anxiety  ☐ Type 1 Diabetes
☐ Arthritis - Rheumatoid Arthritis  ☐ Type 2 Diabetes
☐ Arthritis - Osteoarthritis  ☐ Heart Disease
☐ Arthritis - Other type of arthritis  ☐ High Blood Pressure
☐ Asthma  ☐ High Cholesterol
☐ Cancer  ☐ Migraine Headaches
☐ COPD  ☐ Osteoporosis
☐ Depression  ☐ Stroke

If you have any known medical conditions not listed above, please list them in the box below:
MDVIP HEALTH ASSESSMENT

Your Medical Health

Which of the following preventive and screening services have you had?
Please check all that apply to you.

- [ ] Dental examination in the last year
- [ ] Mammogram in the last 2 years
- [ ] Cervical cancer smear (or PAP test) in the last 3 years
- [ ] Bowel cancer screening in the last 2 to 3 years
- [ ] Ultrasound scan screening for abdominal aortic Aneurysm
- [ ] Flu vaccination in the last year
- [ ] Pneumonia vaccination in the last 5 years
- [ ] Tetanus vaccination in the last 10 years
- [ ] Diabetic eye examination in the last year
- [ ] Diabetic foot examination in the last year
MDVIP HEALTH ASSESSMENT

Your Medical Health

Do you regularly have any of the following bodily symptoms?
Please check all of the symptoms that apply to you.

<table>
<thead>
<tr>
<th>HEAD</th>
<th>ABDOMEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Vision Problems (not including need to wear glasses)</td>
<td>□ Indigestion or Heartburn</td>
</tr>
<tr>
<td>□ Dizziness</td>
<td>□ Excess Gas</td>
</tr>
<tr>
<td>□ Balance Problems</td>
<td>□ Cramps</td>
</tr>
<tr>
<td>□ Difficulty Hearing</td>
<td>□ Bloating</td>
</tr>
<tr>
<td>□ Ringing Ears</td>
<td>□ Constipation</td>
</tr>
<tr>
<td>□ Forgetfulness</td>
<td>□ Diarrhea</td>
</tr>
<tr>
<td>□ Difficulty Concentrating</td>
<td>□ Blood in Stools</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THORAX</th>
<th>UROGENITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Shortness of Breath</td>
<td>□ Frequent Need to Pass Urine (including at night)</td>
</tr>
<tr>
<td>□ Palpitations (fast-beating heart)</td>
<td>□ Incontinence</td>
</tr>
<tr>
<td>□ Cough</td>
<td>□ Burning or Stinging on Passing Urine</td>
</tr>
<tr>
<td>□ Chest Tightness</td>
<td>□ Blood in Urine</td>
</tr>
</tbody>
</table>
Your Medical Health

Which of the following conditions have affected your immediate biological family (your father, mother, sisters and/or brothers)? Please check all that apply to you. Include all conditions you know about, even if your relative is now deceased.

- [ ] Prostate Cancer
- [ ] Bowel cancer
- [ ] Breast Cancer
- [ ] Ovarian Cancer
- [ ] Heart Disease (only if it started before the age of 65 years in a female relative)
- [ ] Heart Disease (only if it started below the age of 55 years in a male relative)
Your Stress

Thinking about your life, on average how stressed and under pressure do you feel? Try to think about all areas of your life, including your work life, home life and family life, before you answer the question.

Mark an ‘X’ along the line that best indicates your answer.

Extremely stressed ________________________________ Not stressed at all

How are you coping with the stress and pressure in your life?

Please check ONE answer only.

☐ Not coping well
☐ Struggling a bit
☐ Coping OK
☐ Coping well
☐ Coping really well

Looking back over the last 3 months, how often have you felt anxious or nervous for no good reason?

Mark an ‘X’ along the line that best indicates your answer.

All of the time ________________________________ Not at all
**Your Stress**

Here is a list of common symptoms of anxiety. How much has each one bothered you during the past week, including today?

Please check one answer for ALL of the symptoms.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Not at all</th>
<th>Mildly</th>
<th>Moderately</th>
<th>Severely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbness and tingling</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Feeling hot</td>
<td></td>
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<tr>
<td>Wobbliness of legs</td>
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<tr>
<td>Unable to relax</td>
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<tr>
<td>Fear of the worst happening</td>
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<tr>
<td>Dizzy or lightheaded</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Heart pounding or racing</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Unsteady</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Terrified</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nervous</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Feelings of choking</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hands trembling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shaky</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Fear of losing control</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Difficulty breathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear of dying</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scared</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Indigestion or discomfort in abdomen (stomach)</td>
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<td></td>
<td></td>
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<tr>
<td>Faint</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Face flushed</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sweating (not due to heat)</td>
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</tbody>
</table>
MDVIP HEALTH ASSESSMENT

Your Stress

Looking back over the last 3 months, how often have you felt sad, miserable or depressed?
Mark an ‘X’ along the line that best indicates your answer.

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Not at all</th>
</tr>
</thead>
</table>

Here is a list of common symptoms of depression. How much has each one bothered you during the past week, including today?
Please check one answer for ALL of the symptoms.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Somewhat</th>
<th>Moderately</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been feeling sad or down in the dumps?</td>
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<tr>
<td>Does the future look hopeless?</td>
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<tr>
<td>Do you feel worthless or think of yourself as a failure?</td>
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<tr>
<td>Do you feel inadequate or inferior to others?</td>
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<tr>
<td>Do you get self-critical and blame yourself for everything?</td>
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<tr>
<td>Do you have trouble making up your mind about things?</td>
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<tr>
<td>Have you been feeling resentful and angry a good deal of the time?</td>
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<tr>
<td>Have you lost interest in your career, your hobbies, your family or your friends?</td>
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<td></td>
<td></td>
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<tr>
<td>Do you feel overwhelmed and have to push yourself hard to do things?</td>
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<tr>
<td>Do you think you’re looking old or unattractive?</td>
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<tr>
<td>Have you lost your appetite, or do you overeat or binge compulsively?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
## MDVIP HEALTH ASSESSMENT

### Your Stress

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Somewhat</th>
<th>Moderately</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you suffer from insomnia and find it hard to get a good night's sleep? Or are you excessively tired and sleeping too much?</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Have you lost your interest in sex?</td>
<td></td>
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</tr>
<tr>
<td>Do you worry a great deal about your health?</td>
<td></td>
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</tr>
<tr>
<td>Do you have thoughts that life is not worth living or think that you might be better off dead?</td>
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</tr>
</tbody>
</table>

**How would you describe the support you are able to get from other people during times of stress?** Think about people who are close to you and you know will help and listen when times are tough

Mark an ‘X’ along the line that best indicates your answer.

I have no support __________________________________________ I have plenty of support
## Pain

### Have you had regular bodily pain over the last month?

Please check one answer to rate your pain in all the body areas below.

<table>
<thead>
<tr>
<th>Area</th>
<th>No pain</th>
<th>Moderate pain</th>
<th>Severe pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Neck</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Shoulders</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Chest</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Abdomen</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Elbows</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Hands and Wrists</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Hips</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Knees</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Feet and Ankles</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Back</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
Sleep

How many hours of sleep do you get on a typical weekday night and a typical weekend or non-working night?

Write down the hours and minutes of sleep that you get.

How many hours of sleep do you get on a typical weekday/work-night?

Hours

Minutes

How many hours of sleep do you get on a typical weekend/non-work night?

Hours

Minutes
MDVIP HEALTH ASSESSMENT

Sleep

How often do you find you have difficulty falling asleep or difficulty staying asleep at night?

Please check ONE answer only.

□ I have these problems most nights
□ I have these problems at least 2 or 3 times a week
□ I have these problems about once a week
□ I occasionally have these problems, but less than once a week
□ I virtually never have these sort of problems

On a regular week day when you wake up in the morning and have gotten yourself out of bed and ready for the day ahead, how rested and refreshed do you feel?

Please check ONE answer only.

□ Exhausted
□ Very tired
□ Quite tired
□ A little tired
□ Completely rested

Overall, how satisfied are you with the amount and quality of the sleep that you usually get?

Please check ONE answer only.

□ Very unsatisfied
□ Unsatisfied
□ OK
□ Satisfied
□ Very satisfied
Your Work

Which of the following best describes your current employment status?

Please check ONE answer only.

☐ Employed (Full-time)
☐ Employed (Part-time)
☐ Not working for pay (Student)
☐ Not working for pay (Stay-at-home parent)
☐ Not working for pay (Full-time career)
☐ Unemployed
☐ Retired
☐ Other
Your Sexual Health

Are you satisfied with your sex life?
Please check ONE answer only.

- □ Never
- □ Sometimes
- □ Most times
- □ Always
- □ I prefer not to answer this (if you select this answer, please skip the following Sexual Health questions)

FEMALES ONLY! Please answer the following questions. Thinking back over the past 6 months...
Please check one answer for ALL of the questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Most times</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you satisfied with your level of sexual desire or interest?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with your level of lubrication during sexual activity or intercourse?</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you experience discomfort or pain during sexual activity or intercourse?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Your Sexual Health

**MALES ONLY!** Please answer the following questions. Thinking back over the past 6 months...

Please check one answer for ALL of the questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Very Low</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Very High</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you rate your confidence that you can get and keep an erection?</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Did not attempt intercourse</th>
<th>Almost never or Never</th>
<th>A few times</th>
<th>Sometimes</th>
<th>Most times</th>
<th>Almost always or Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?</td>
<td></td>
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</tr>
<tr>
<td>When you attempted sexual intercourse, how often was it satisfactory for you?</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Did not attempt intercourse</th>
<th>Extremely difficult</th>
<th>Very difficult</th>
<th>Difficult</th>
<th>Slightly difficult</th>
<th>Not difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Your Safety

When you are driving or riding in a car, do you wear a seat belt?
Please check ONE answer only.

☐ Never
☐ Sometimes
☐ Most times
☐ Always

Do you feel or have you ever felt unsafe or threatened in your home environment or relationships?
Please check ONE answer only.

☐ Yes
☐ No (if you select this answer, please skip the following question)

You said that you have at some time felt unsafe or threatened: 
Please check one answer for ALL of the questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever been in a relationship where you have been physically harmed or threatened with physical violence?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Are your friends or family aware of this situation?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do you have a safe place to go and the resources you need in an emergency?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do you feel safe in all of your current relationships?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Your Overall Health & Happiness

In general, taking all things into account, how would you rate your overall health?

Please check **one** answer only.

- [ ] Excellent
- [ ] Very good
- [ ] Good
- [ ] Fair
- [ ] Poor

In general, taking all things into account, how would you rate your satisfaction and happiness with your life?

Please check **one** answer only.

- [ ] Excellent
- [ ] Good
- [ ] OK
- [ ] Not good
- [ ] Terrible
MDVIP HEALTH ASSESSMENT

Making Changes

How important is it to make changes to your lifestyle to improve your health?
Mark an ‘X’ along the line that best indicates your answer.

Very important

Not important

How ready are you to start making these changes?
Mark an ‘X’ along the line that best indicates your answer.

I’m ready

Not ready

How confident are you that you’ll succeed?
Mark an ‘X’ along the line that best indicates your answer.

Very confident

Not confident