

Stevens Institute of Technology Recreational Services

Self-Assessment Quiz

The following questionnaire is designed to increase your knowledge and awareness of your overall health, and to highlight potential areas of concern. Keep in mind that although health risks associated with age, gender and heredity are beyond your control, you can modify a range of other factors, such as blood pressure, smoking, blood cholesterol levels, exercise, diet, stress, and excess body weight.

SECTION A: PHYSICAL FITNESS

1. Do you exercise or play a sport for at least 30 minutes three or more times a week? Yes No
 2. Do you warm up and cool down by stretching before and after exercising? Yes No
 3. Do you fall into the appropriate weight category for someone your height and gender? Yes No
 4. In general, are you pleased with the condition of your body? Yes No
 5. Are you satisfied with your current level of energy? Yes No
 6. Do you use stairs rather than escalators or elevators whenever possible? Yes No
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SECTION B: FAMILY HISTORY

Do you have a grandparent, parent, aunt, uncle, brother, or sister who:

1. Had a heart attack before age forty? Yes No
2. Had high blood pressure requiring treatment? Yes No
3. Developed diabetes? Yes No
4. Developed glaucoma? Yes No
5. Developed gout? Yes No
6. Developed breast cancer? Yes No

SECTION C: SELF-CARE AND MEDICAL CARE

1. Do you floss your teeth daily? Yes No
2. Do you have a dental checkup at least one a year? Yes No
3. Do you use sunscreen regularly and avoid extensive exposure to the sun? Yes No
4. For women: do you examine your breasts for unusual changes or lumps at least once a month? Yes No
5. For men: do you examine your testicles for unusual changes or lumps at least once a month? Yes No
6. Do you usually know what to do in case of illness or injury? Yes No
7. Do you avoid unnecessary X-rays? Yes No
8. Do you normally get an adequate amount of sleep? Yes No
9. Have you had your blood pressure checked in the past year? Yes No
10. For women: have you had a Pap smear within the last two years? Yes No
11. If you are over forty: have you had a test for glaucoma within the last four years? Yes No
12. If you are over forty: have you had a test for hidden blood in your stool with in the last two years? If you are over fifty: within the last year? Yes No
13. If you are over fifty: have you had at least one endoscopic exam of the lower bowel? Yes No

SECTION D: EATING HABITS

1. Do you drink enough fluids so that your urine is a pale yellow color? Yes No
2. Do you try special or fad diets? Yes No
3. Do you add salt to foods during cooking and at the table? Yes No
4. Do you minimize your intake of sweets, especially candy and soft drinks, and avoid adding sugar to foods? Yes No

5. Is your diet well-balanced (including vegetables, fruits, breads, cereals, dairy products, and adequate sources of protein)? Yes No
 6. Do you limit your intake of saturated fats (butter, cheese, cream, fatty meats)? Yes No
 7. Do you limit your intake of cholesterol (eggs, liver, meats)? Yes No
 8. Do you eat fish and poultry more often than red meats? Yes No
 9. Do you eat high-fiber foods (vegetables, fruits, whole grains) several times a day? Yes No
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SECTION E: ALCOHOL, NICOTINE, AND OTHER DRUG USE

1. Do you smoke cigarettes, cigars, or a pipe, chew tobacco, or use other drugs? Yes No
 2. Do you limit yourself to no more than two drinks a day? Yes No
 3. Have family members or friends ever commented on or complained about your drinking or your use of other drugs? Yes No
 4. Have you been unable to recall things you did when you are drinking or using other drugs? Yes No
 5. Do you use alcohol or other drugs as a way of handling stressful situations or problems in your life? Yes No
 6. Do you read and follow the label directions when using prescribed and over-the-counter drugs? Yes No
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SECTION F: ACCIDENTS

1. Do you drive after drinking alcohol or using other drugs, or ride with drivers who have been drinking or using other drugs? Yes No
2. Do you obey traffic rules and stay within the speed limit when you drive? Yes No
3. As a driver and passenger, do you wear a seat belt at all times? Yes No
4. Are the vehicles you drive well maintained? Yes No

5. Do you smoke in bed? Yes No
6. Are you informed and careful when using potentially harmful products or substances, such as household cleaners, poisons, flammables, solvents, and electrical devices? Yes No
7. Do you own a gun? Yes No
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SECTION G: INTELLECTUAL, LIFE, VALUES, AND SPIRITUALITY

1. Are you interested in, and do you keep up to date on, social and political issues? Yes No
2. Are you satisfied with what you do for entertainment? Yes No
3. Do you engage in creative and stimulating activities as often as you would like? Yes No
4. Are you satisfied with the degree to which you work is consistent with your values? Yes No
5. Are you satisfied with the degree to which your leisure activities are consistent with your values? Yes No
6. Is it difficult for you to accept the values and life-styles of others when they are different from your own? Yes No
7. Are you satisfied with your spiritual life? Yes No
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SECTION H: STRESS AND SOCIAL SUPPORT

1. Are you satisfied with the amount of excitement in your life? Yes No
2. Do you find it easy to laugh? Yes No
3. Do you hold in your angry feelings without expressing them? Yes No
4. Do you make decisions with minimum stress and worry? Yes No
5. Do you include relaxation time as part of your daily routine? Yes No
6. Do you anticipate and prepare for events or situations likely to be stressful? Yes No
7. Have you had to make difficult readjustments at home or work in the past year? Yes No

8. Has a family member or close friend died, been seriously ill, or been injured within the past year? Yes No
 9. Are you a chronic worrier, subject to guilt feelings or self-punishment? Yes No
 10. Have your health, eating, or sleeping habits changed as a result of a stressful incident or situation during the past year? Yes No
 11. Are you able to fall asleep when you are ready and are able to sleep through the night uninterrupted? Yes No
 12. Do you wake up feeling rested? Yes No
 13. Do you have one or more persons with whom you can discuss personal concerns, worries, or problems? Yes No
 14. Do they make you feel respected and/or admired? Yes No
 15. Is there someone to whom you can turn if you need help, such as to lend you money? Yes No
 16. Are you satisfied with the support you provide to others? Yes No
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SECTION I: ENVIRONMENT

1. Are you often in an environment that has significant air and/or noise pollution? Yes No
2. Are you often exposed to asbestos, vinyl chloride, formaldehyde, or other toxins? Yes No
3. Do you miss many days at work due to illness or just not feeling up to it? (“Work” refers to the daily activities, including school or work in the home). Yes No
4. Do you often sit for periods of an hour or more at a time? Yes No
5. Are you satisfied with your ability to plan your workload? Yes No
6. Do you receive adequate feedback to judge your performance? Yes No
7. Are you satisfied with your balance between work and leisure time? Yes No

SECTION J: SEXUALITY

1. Are you satisfied with your level of sexual activity? Yes No
2. Are you satisfied with your sexual relationship? Yes No
3. Are you satisfied with your use (or nonuse) of contraceptives? Yes No
4. Are you satisfied with your use (or nonuse) of “safer sex” practices?
 Yes No

When you complete this Quiz, take time to reflect on your answers. Review each section to see where you may need a significant increase in your health and satisfaction in those areas. Work first on those areas where you are most likely to be successful, then tackle the tougher sections.