MEN'S HEALTH EVENT

Identification Number: _______________ **Date of Birth:** ______________ **Zip Code:** _____________

How did you hear about this event? ____

Demographic Information

Race: *(please check the one you most identify with)* ☐ Black/African American ☐ White/Caucasian
☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ Other

Ethnicity: Do you identify as Hispanic or Latino? ☐ Yes ☐ No

Have you ever tested Covid-19 positive? ☐ Yes ☐ No

Have you received the Covid-19 vaccine? ☐ Yes ☐ No

If no, do you plan on receiving the Covid-19 vaccine? ☐ Yes ☐ No

If no, why are you hesitant? ____

Do you have any issues with wearing a mask or social distancing? ☐ Yes ☐ No

How afraid are you of getting Covid-19? (1-not afraid, 5-very afraid)

1	2	3	4	5

What is your age range (in years)? ☐ Under 40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 71-80 ☐ 80 +

Do you **look** older than your age? ☐ Older ☐ My age ☐ Younger

Do you **feel** older than your age? ☐ Older ☐ My age ☐ Younger

What age do you think you're going to live until? ☐ Under 40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 71-80 ☐ 80 +

Why did you come to Ford Field today? ____

Have you attended a Men's Health Event before? ☐ Yes ☐ No

Did you follow up with a healthcare professional for that issue? ☐ Yes ☐ No

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Marital Status: ☐ Married / Partner / Significant Other ☐ Single / Divorced / Widowed

How involved is your significant other in making your medical decisions? ☐ Very ☐ Somewhat ☐ Not at all

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Are you a father? ☐ Yes ☐ No Do you have children living at home with you? ☐ Yes ☐ No

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Education:
☐ Did not finish high school ☐ High School graduate or GED ☐ Some college ☐ 4 or more years college

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Are you employed? ☐ Yes ☐ No Are you retired? ☐ Yes ☐ No Are you a veteran? ☐ Yes ☐ No

Annual Income Level: ☐ less than $35,000 ☐ $35,000-59,999 ☐ more than $60,000

Are you receiving disability payments? ☐ Yes ☐ No

Do you have health insurance? ☐ No ☐ Medicare ☐ Medicaid ☐ Private Insurance ☐ VA Insurance

If you don't have insurance, why? ☐ Can't afford it ☐ Haven't taken the time to research what's out there
☐ Waiting for sign-up period ☐ Don't need it

Where do you usually get medical information to educate yourself from?
☐ Doctor/Healthcare provider ☐ Internet ☐ Newspaper or Magazine ☐ Radio
☐ Friend/Family ☐ TV ☐ Health Fairs ☐ I don't research health issues

Medical History

Do you have a medical doctor/healthcare provider you regularly see? ☐ Yes ☐ No

When was the last time you were seen by a medical doctor/healthcare provider?
☐ 0-1 Year ☐ 1-5 Years ☐ > 5 Years If not every year, please tell us why ____________________

When do you normally see your doctor/healthcare provider? ☐ Only when I'm having a problem ☐ Routinely, even if I'm feeling well ☐ Never

How often do you think a man should see a doctor/healthcare provider **if he's feeling well?**
☐ Never ☐ Every 3 months ☐ Every 6 months ☐ Every 1 year ☐ Other ______________

Have you or a family member ever been treated for the following?

Condition	Myself	Family Member
Heart Disease	☐ Myself	☐ Family Member
Heart Attack	☐ Myself	☐ Family Member
High Blood Pressure	☐ Myself	☐ Family Member
Stroke	☐ Myself	☐ Family Member
Diabetes - Insulin	☐ Myself	☐ Family Member
Diabetes - Non Insulin	☐ Myself	☐ Family Member
Arthritis	☐ Myself	☐ Family Member
Colorectal Polyps	☐ Myself	☐ Family Member
Prostate Cancer	☐ Myself	☐ Family Member
Alcohol-Related Problems	☐ Myself	☐ Family Member
Depression	☐ Myself	☐ Family Member
Anxiety Disorder	☐ Myself	☐ Family Member
COPD or Asthma	☐ Myself	☐ Family Member
Other Cancer _____________	☐ Myself	☐ Family Member

In general...

Are you taking any prescription medication? ☐ Yes ☐ No

Are you taking any over-the-counter supplements? ☐ Yes ☐ No

Do you experience pain on a daily basis? ☐ Yes ☐ No

Do you take over-the-counter pain medication on a daily basis? ☐ Yes ☐ No

Do you take prescription pain medicine on a daily basis? ☐ Yes ☐ No

Do you have any problems urinating? ☐ Yes ☐ No

Do you take medication to decrease the times you wake to urinate at night? ☐ Yes ☐ No

How would you rate your sexual desire (libido)? ☐ High ☐ Low ☐ Normal

How often do you have sex? ☐ Daily ☐ Weekly ☐ Monthly ☐ A few times a year ☐ Not sexually active

Do you take medication for erections (Viagra, Levitra, or Cialis) or use injections, pumps? ☐ Yes ☐ No

In general, would you say your **health** is: ☐ Very Good ☐ Fair ☐ Poor

Do you see yourself as: ☐ Underweight ☐ Normal Weight ☐ Overweight ☐ Obese

Does your current health limit your daily activities? (for example, climbing stairs, vacuuming, or bowling)
☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all

Compared to one year ago, how would you rate your health in general now? ☐ Better ☐ Same ☐ Worse

Has your doctor/healthcare provider talked to you about screening for testicular cancer? ☐ Yes ☐ No

Do you perform testicular self-exams? ☐ No ☐ Yes, about once a year ☐ Yes, every month

Do you think you would recognize testicular cancer if you had it? ☐ Yes ☐ No

Lifestyle

Caffeine: (coffee, soda, energy drinks, etc.) ☐ None ☐ 2 cups or less per day ☐ more than 2 cups per day

Alcohol intake: ☐ None ☐ 2 drinks or less per day ☐ more than 2 drinks per day

Tobacco:

Do you currently use tobacco? ☐ Yes ☐ No # packs/day _______

Do you use E-cigarettes or vape? ☐ Yes ☐ No

If not using tobacco now, any past use? ☐ Yes ☐ No

Are you homeless?
☐ Yes ☐ No

Drugs:

Do you use marijuana? ☐ Yes ☐ No

Do you use street drugs? ☐ Yes ☐ No

Do you have a smartphone?
☐ Yes ☐ No

Diet:

Do you consume red meat more than 3 times per week? ☐ Yes ☐ No

Do you consume "Fast Food" more than 3 times per week? ☐ Yes ☐ No

Do you eat more than 3 servings of fruits and vegetables per day? ☐ Yes ☐ No

Exercise:

Do you lift weights more than 3 times per week? ☐ Yes ☐ No

Do you run, walk, bike or swim more than 3 times per week? ☐ Yes ☐ No

What is the longest you sit per day, at any one given time? ☐ More than 3 hours ☐ Less than 3 hours

Religion and Spirituality:

Are you spiritual or religious? ☐ Yes ☐ No

Do you pray or meditate? ☐ Yes ☐ No

Sleep:

How many hours of sleep do you get per night on average? ☐ More than 8 ☐ 6-8 ☐ Less than 6

How many times do you wake per night to urinate? ☐ Zero ☐ 1 time ☐ 2 or more times

When you wake in the morning, do you feel rested? ☐ Yes ☐ No

What is the quality of your sleep? ☐ Good ☐ Poor

Food Security:

Within the past 12 months, have you worried that food for your family would run out before you got money to buy more? ☐Often True ☐Sometimes True ☐Never True

Does some or all of your food come from a food assistance program (bridge card, food bank, shelter, etc.)?
☐ Yes ☐ No

OVER

Wellness

How would you rate your average level of stress during the past month?

Little or no stress --> | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | *<-- A great deal of stress*

Have you experienced any of the following in the last year: Marriage, divorce, death of someone close to you, job change or loss, move, financial difficulty, medical issue, or legal issue? ☐ Yes ☐ No

Thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the ***past 30 days*** was your mental health **not** good? _______ days (Options: 0-30 days)

Thinking about your physical health, which includes physical illness and injury, for how many days during the ***past 30 days*** was your physical health **not** good? _______ days (Options: 0-30 days)

During the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than Half of the Days	Nearly Everyday
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed or hopeless	0	1	2	3
3 Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

10 If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

MIU MEN'S HEALTH FOUNDATION

Thank you for completing this survey.
All answers will be kept strictly confidential!

FIGHT like a MAN DETROIT