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Willows, CA 95988
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Health Survey Questionnaire for Glenn Medical Center

1. How would you describe your overall health?

☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

2. Please select the top three health challenges you face.

☐ Cancer
☐ High blood pressure
☐ Mental health issues
☐ Diabetes
☐ Stroke
☐ Alcohol overuse
☐ Overweight/obesity
☐ Heart Disease
☐ Drug addiction
☐ Lung disease
☐ Joint pain or back pain
☐ I do not have any health challenges
☐ Other (please specify)____

3. Where do you go for routine health care?

☐ Physician's office
☐ Health department
☐ Emergency room
☐ Urgent care clinic
☐ Other clinic
☐ I do not receive routine health care
☐ I would not seek health care

In what community do you receive this care?____

4. Where would you go for emergency medical services if you were able to take yourself?

☐ Physician's office
☐ Health department
☐ Emergency room
☐ Urgent care clinic
☐ Other clinic
☐ I do not receive routine health care
☐ I would not seek health care

In what community do you receive this emergency service? ____________________________________

5. Are there any issues that prevent you from accessing care? (check all that apply)

☐ Cultural/religious beliefs

☐ Don't know how to find doctors

☐ Don't understand the need to see a doctor

☐ Fear (e.g., not ready to face/discuss health problem)

☐ Lack of availability of doctors

☐ Language barriers

☐ No insurance and unable to pay for the care

☐ Unable to pay co-pays/deductibles

☐ Transportation

☐ Other (please specify) ______________________________

6. What is needed to improve the health of your family and neighbors? (Check three.)

☐ Healthier food
☐ Mental health services
☐ Transportation
☐ Specialty physicians
☐ Safe places to walk/play
☐ I don't know
☐ Job opportunities
☐ Recreation facilities
☐ Wellness services
☐ Free or affordable health screenings
☐ Substance abuse rehabilitation services
☐ Other (please specify) ________________________________

7. What types of health screenings and/or services are needed to keep you and your family healthy? (Check up to five.)

☐ Blood pressure
☐ Cancer
☐ Cholesterol (fats in blood)
☐ Dental screenings
☐ Diabetes
☐ Disease outbreak prevention
☐ Drug and alcohol abuse
☐ Mental health/depression
☐ Emergency preparedness
☐ Exercise/physical activity
☐ Falls prevention for elderly
☐ Heart disease
☐ HIV/AIDS & STDs
☐ Routine well checkups
☐ Memory loss
☐ Other (please specify)____________________________
☐ Nutrition
☐ Prenatal care
☐ Quit smoking
☐ Suicide prevention
☐ Vaccinations
☐ Weight-loss help
☐ Eating disorders

8. What health issues do you need education about? (Please check up to five.)

☐ Blood pressure
☐ Cancer
☐ Cholesterol (fats in blood)
☐ Dental screenings
☐ Diabetes
☐ Disease outbreak prevention
☐ Drug and alcohol abuse
☐ Mental health/depression
☐ Emergency preparedness
☐ Exercise/physical activity
☐ Falls prevention for elderly
☐ Heart disease
☐ HIV/AIDS & STDs
☐ Routine well checkups
☐ Memory loss
☐ Other (please specify)_____________________________
☐ Nutrition
☐ Prenatal care
☐ Quit smoking
☐ Suicide prevention
☐ Vaccinations
☐ Weight-loss help
☐ Eating disorders

9. Where do you get most of your health information? (Check all that apply.)

☐ Doctor/healthcare provider
☐ Facebook or Twitter
☐ Other social media
☐ Family or friends
☐ Health department
☐ Hospital
☐ Internet
☐ Library
☐ Newspaper/magazine
☐ Radio
☐ Church group
☐ School or college
☐ TV
☐ Worksite
☐ Other (please specify)

10. What additional health services need to be offered to meet health challenges in your community?

11. Please choose all statements below that apply to you.

☐ I exercise at least three times per week.

☐ I eat at least five servings of fruits and vegetables each day.

☐ I eat fast food more than once per week.

☐ I smoke cigarettes.

☐ I chew tobacco.

☐ I use illegal drugs.

☐ I abuse or overuse prescription drugs.

☐ I have more than four alcoholic drinks (if female) or five (if male) per day.

☐ I use sunscreen or protective clothing for planned time in the sun.

☐ I receive a flu shot each year.

☐ I have access to a wellness program through my employer.

☐ None of the above apply to me.

12. Which of the following preventive procedures have you had in the past 12 months?

☐ Mammogram (woman)
☐ Prostate screening (man)
☐ Hearing screening
☐ Bone density test
☐ Blood sugar check
☐ None of the above
☐ Pap smear (woman)
☐ Cholesterol screening
☐ Cardiovascular screening
☐ Blood pressure check
☐ Skin cancer screening
☐ Flu shot
☐ Vision screening
☐ Colon/rectal exam
☐ Dental cleaning/x-rays
☐ Physical exam

13. How can Glenn Medical Center better meet your health care needs?

14. Optional: What is your gender?

☐ Male ☐ Female

15. Optional: Which category below includes your age?

☐ Under 18 ☐ 18-29 ☐ 30-39
☐ 40-49 ☐ 50-59 ☐ 60-69
☐ 70-79 ☐ 80-89 ☐ 90+

16. Optional: What is your highest level of education?

☐ K-8 grade ☐ Some high school ☐ High school graduate
☐ Technical school ☐ Some college ☐ College graduate
☐ Graduate school ☐ Doctorate ☐ Other (please specify)

17. Optional: Do you have health insurance?

☐ Yes ☐ No ☐ No, but I did previously

18. Optional: Do you need a Primary Care Physician? (Family Practice/Internal Medicine). If so, please provide your contact information at the end of the survey.

☐ Yes ☐ No

19. Are you in need of a health specialist? Please check all that apply and include your contact information at the end of the survey.

☐ Cardiology ☐ Obstetrics ☐ Thoracic surgery
☐ Electrophysiology ☐Bariatric/Weight loss ☐ Vascular surgery
☐ Orthopedics ☐ General surgery ☐ Oncology
☐ Neurology ☐ Gastroenterology ☐ Plastic Surgery
☐ Neurosurgery ☐ Urology ☐ Pain management
☐ Colorectal ☐ Oncology ☐ Wound healing
☐ Gynecology ☐ Breast Health ☐ Sleep Disorders
☐ Other (please specify) ________________________________

Please list any areas in which our service could be improved.

Please share any additional comments.

Personal Information

Providing the following information is optional.

First Name	Last Name	Gender	Age
Address	City	State	ZIP Code
Email	Phone		

Would you like someone to contact you regarding your responses on this survey?

☐ Yes | ☐ No

Thank you for taking the time to fill out our survey.