# MEDICAL HEALTH QUESTIONNAIRE

This form asks you a variety of questions about your medical condition and takes about 5 minutes to complete. There are some demographic questions in order to help me with ongoing research. Your answers to these questions will be maintained in privacy and will not be associated with your name in any research. Please fill in the information requested, or place a check in the appropriate space. I thank you for your time and effort in completing this questionnaire.

Please print your name:_____ Today's Date: _____

Please circle the highest grade in school you have completed:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Elementary School | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| High School | 9 | 10 | 11 | 12 | | | | |
| College/Post Grad | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20+ |

What is your marital status:

___Single ____Partner ___Married ___Widowed ___Divorced/Separated

What is your race or ethnic background?

___ White, not of Hispanic origin
___ American Indian/Alaskan Native
___ Asian
___ Black, not of Hispanic origin
___ Pacific Islander
___ Hispanic
___ Other

What is your job or occupation? (Check the one that applies to the greatest percentage of your time)

| | | |
|---|---|---|
| ___ Health Professional | ___ Disabled, unable to work | ___ Service |
| ___ Manager, educator, professional | ___ Operator, fabricator, laborer | ___ Unemployed |
| ___ Skilled crafts | ___ Homemaker | ___ Student |
| ___ Technical, Sales, support | ___ Retired | ___ Other |

How long have you exercised or played sports regularly?

| | | |
|---|---|---|
| ___ I do not exercise regularly | ___ Less than 1 year | ___ 1 to 2 years |
| ___ 2 to 5 years | ___ 5 to 10 years | ___ more than 10 years |

Known Diseases

1. Do you have personal history of heart disease? ___
2. Any personal history of metabolic disease (thyroid, renal, liver) ___
3. Have you had diabetes for less than 15 years? ___
4. Have you had diabetes for 15 years or more? ___

Symptoms or Signs suggestive of Disease

5. Have you experienced unusual pain or discomfort in your chest, neck, jaw, arms, or other areas that may be due to heart problems? ___

6. Have you experienced unusual fatigue and/or shortness of breath at rest, during usual activities, or during mild-to-moderate exercise (climbing stairs, carrying groceries, etc.,)? ___
7. Have you had any problems with dizziness or fainting? ___
8. When you stand up, or sometimes during the night while you are sleeping, do you have difficulty breathing? ___
9. Have you experienced an unusual and rapid throbbing or fluttering of the heart? ___
10. Do you suffer from swelling of the ankles (ankle edema)? ___
11. Have you experienced severe pain in your leg muscles during walking? ___
12. Has a doctor told you that you have a heart murmur? ___

Chronic Disease Risk Factors

13. Is your total serum cholesterol greater than 240 mg/dl, or has a doctor told you that your cholesterol is at a high risk level? ___
14. Are you a current cigarette smoker? ___
15. Is your serum HDL (The "good" cholesterol) over 60 mg/dl? ___
16. Are you physically inactive and sedentary (little physical activity on the job or during leisure time)? ___
17. Has a doctor told you that you have high blood pressure (more than 140/90 mm HG), or are you on medication to control your blood pressure? ___
18. Has your father or brother had a heart attack or died suddenly of heart disease before age 55 years? ___ Has your mother or sister experienced these heart problems before age 65 years? ___

Medical/Health Screening History

19. During the past year, would you say that you experienced enough stress, strain, and pressure to have a significant effect on your health? ___
20. Do you eat food nearly every day that are high in fat and cholesterol such as fatty meats, cheese, fried foods, butter, whole milk or eggs? ___
21. Do you tend to avoid foods that are high in fiber such as whole grain breads and cereals, fresh fruits or vegetables? ___
22. Do you weigh 30 or more pounds than you should? ___
23. Do you average more than two alcoholic drinks each day? ___

Please check the item that most closely matches:

24. When did you have your last medical exam? ___Less than a year ___1 year ago___2 years ago ___3 or more years ago ___Never
25. When did you have your last dental exam? ___Less than a year ___1 year ago___2 years ago ___3 or more years ago ___Never
26. When did you last have your blood pressure tested? ___Less than a year ___1 year ago___2 years ago ___3 or more years ago ___Never
27. When did you last have your blood cholesterol tested? ___Less than a year ___1 year ago___2 years ago ___3 or more years ago ___Never

28. If you have ever had a treadmill-E.C.G. stress test, please indicate how long ago the test was performed. Otherwise, please check "Never". ___Less than a year ___1 year ago___2 years ago ___3 or more years ago ___Never
29. About how long has it been since you had a rectal exam? ___Less than a year ___1 year ago___2 years ago ___3 or more years ago ___Never

For Men Only:

30. About how long has it been since you had a rectal exam? ___Less than a year ___1 year ago___2 years ago ___3 or more years ago ___Never

For Women Only:

31. How often do you examine your breast for lumps? ___Monthly ___Once every few months ___rarely or never
32. About how long has it been since you had your breast examined by a physician or nurse? ___Less than a year ___1 year ago___2 years ago ___3 or more years ago ___Never
33. How long has it been since your last breast x-ray (mammogram)? ___Less than a year ___1 year ago___2 years ago ___3 or more years ago ___Never
34. How long has it been since you had a Pap smear test? ___Less than a year ___1 year ago___2 years ago ___3 or more years ago ___Never

Medical History

35. Please check which of the following conditions you have had or now have. Also check medical conditions in your family (father, mother, brother(s), or sister (s). Check as many as apply.

| Medical Condition | Personal | Family |
|---|---|---|
| Angina | _____ | _____ |
| Peripheral vascular disease | _____ | _____ |
| Phlebitis or emboli | _____ | _____ |
| Other heart problems | | |
| Please specify _____ | | |
| Lung Cancer | _____ | _____ |
| Breast Cancer | _____ | _____ |
| Prostate Cancer | _____ | _____ |
| Colorectal Cancer (bowel) | _____ | _____ |
| Skin Cancer | _____ | _____ |
| Other Cancer | | |
| Please specify _____ | | |
| Stroke | _____ | _____ |
| Chronic obstructive | _____ | _____ |
| Pulmonary (emphysema) | _____ | _____ |
| Pneumonia | _____ | _____ |

| | | |
|---|---|---|
| Asthma | _____ | _____ |
| Bronchitis | _____ | _____ |
| Diabetes Mellitus | _____ | _____ |
| Thyroid Problems | _____ | _____ |
| Kidney Disease | _____ | _____ |
| Liver Disease (Cirrhosis) | _____ | _____ |
| Hepatitis | _____ | _____ |
| Gallstones/Gallbladder | _____ | _____ |
| Osteoporosis | _____ | _____ |
| Arthritis | _____ | _____ |
| Gout | _____ | _____ |
| Anemia (low iron) | _____ | _____ |
| Bone Fracture | _____ | _____ |
| Major injury to foot, leg, knee, hip or shoulder | _____ | _____ |
| Major injury to back or neck | _____ | _____ |
| Stomach/duodenal ulcer | _____ | _____ |
| Rectal growth or bleeding | _____ | _____ |
| Cataracts | _____ | _____ |
| Glaucoma | _____ | _____ |
| Hearing Loss | _____ | _____ |
| Depression | _____ | _____ |
| High anxiety, phobias | _____ | _____ |
| Substance abuse problems (alcohol, drugs) | _____ | _____ |
| Eating disorders (anorexia, bulimia) | _____ | _____ |
| Problems with menstruation | _____ | _____ |
| Hysterectomy | _____ | _____ |
| Sleeping problems | _____ | _____ |
| Allergies | _____ | _____ |

Any other health problems:

Please specify and include information on any recent illnesses, hospitalizations or surgical procedures:

_____

_____

_____

Please check any of the following medications you currently take regularly. Also give the name of the medication.

| Medication | Name of Medication |
|---|---|
| ___Heart | _____ |

___Blood Pressure _____
___Blood Cholesterol _____
___Hormones _____
___Birth Control _____
___Medicine for breathing/lungs _____
___Insulin _____
___Other medicine for diabetes _____
___Arthritis medicine _____
___Medicine for Depression _____
___Medicine for anxiety _____
___Thyroid Medicine _____
___Medicine for ulcers _____
___Pain killer medicine _____
___Allergy medicine _____
___Other
Please specify _____
_____

37. Do you use a vitamin/mineral supplements on a regular basis? ___ Yes ___No
If "YES", please specify: _____
38. Do you use other nutritional supplements such as herbs, amino acids, bee pollen, ginseng, etc., on a regular basis? NOTE: Include all supplements listed in the MHQ reports.

_____
_____
_____

Occupational Health

39. Please describe your main job duties:

_____
_____

40. After a day's work, do you often have pain or stiffness which last for more than 3 hours?
___All of the time ___Most of the time ___Some of the time ___Never

41. How often does your work entail repetitive pushing and pulling movements or lifting while bending or twisting, leading to back pain?
___All of the time ___Most of the time ___Some of the time ___Never
42. How often are there high noise levels on the job so that you have to raise your voice to be heard? ___All of the time ___Most of the time ___Some of the time ___Never
43. How often do you handle chemicals on the job which could come in contact with your skin and cause skin rashes and itching?
___All of the time ___Most of the time ___Some of the time ___Never
44. How often does the air you breathe at work contain dust or chemical fumes that cause irriation? ___All of the time ___Most of the time ___Some of the time ___Never