

Medical History



Executive Health Physicals

Please fill out this form as accurately as possible, and return to Lafayette General Imaging prior to your exam. The physician will use this information to complete your health assessment. All information will be kept confidential.

I. GENERAL INFORMATION

A. Personal

Title <input type="radio"/> Mr. <input type="radio"/> Mrs. <input type="radio"/> Ms. <input type="radio"/> Miss <input type="radio"/> Dr. <input type="radio"/> Rev. <input type="radio"/> Other_____

Last Name: _____

First Name: _____

Middle Name: _____

Maiden Name (if applicable): _____

End <input type="radio"/> Jr. <input type="radio"/> Sr. <input type="radio"/> II <input type="radio"/> III <input type="radio"/> M.D. <input type="radio"/> D.D.S. <input type="radio"/> Other_____

Social Security Number: _____

Age: _____

Date of Birth: _____

Mother's Maiden Name: _____

Home Phone: _____

Home Fax: _____

Number & Street Address: _____

City: _____

State: _____

Zip Code: _____

B. OCCUPATION (If not employed at this time, skip to Present Work Situation)

Name of Business or Employer: _____

Type of Business: _____

I. GENERAL INFORMATION (CONT.)



Your Position, Title, or Type of Work: _____

Complete Office Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone: _____ Business Fax: _____

What is your present work situation? (Bubble in all that apply)

- | | | | |
|------------------------------------------|-------------------------------------|-------------------------------------|---------------------------------|
| <input type="radio"/> Employed full-time | <input type="radio"/> Semi-retired | <input type="radio"/> Self-Employed | <input type="radio"/> Housewife |
| <input type="radio"/> Employed Part-time | <input type="radio"/> Fully-Retired | <input type="radio"/> Unemployed | <input type="radio"/> Student |

If retired, give retirement date: _____

E-Mail

Personal: _____ Business: _____

C. PERSONAL PHYSICIAN

Last Name: _____ First Name: _____ M.I. _____

Complete Office Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone Number: _____ Office Fax Number: _____

Speciality: _____

D. OTHER HEALTH DATA

1. How many days of work did you lose due to illness in the past year? _____

2. How many times did you see a physician for medical reasons last year? _____

I. GENERAL INFORMATION (CONT.)



3. Name, Address and Phone Number of Spouse:

Name: _____

Number and Street Address: _____

City: _____ Home Phone Number: _____

State: _____ Zip Code: _____ Work Phone Number: _____

4. Name, Address, and Phone Number of person to be notified in case of emergency:

If same as Question 3, mark here and go to section II.

Name: _____ Relationship to patient _____

Number and Street Address: _____

City: _____ Home Phone Number: _____

State: _____ Zip Code: _____ Work Phone Number: _____

II. PERSONAL PROFILE

Sex: Male Female

Race: White Black Hispanic Asian American Indian

Other (specify): _____

Place of Birth: _____

A. Marital History

1. Are you now or have you ever been married? Yes No

If yes, how many times have you been married? _____

2. Current marital status: Single Married Divorced Widowed

If you are currently married, how many years? _____

3. Number of children? _____

IV. REVIEW OF SYSTEMS

Please indicate whether you have ever had a significant problem with any of the symptoms or conditions listed below.

	Yes	No	Don't Know	If yes, year of onset?	Still a problem? (Mark Yes or No)
HEART/VASCULAR					
Chest pain or pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Chest pain with exertion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Heart attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Rapid or irregular heartbeats	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Fainting or lightheadedness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Rheumatic fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Calf pain with exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Varicose veins	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Blood clots	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
High blood cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
High blood triglycerides	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No

EYES

Date of last eye exam? _____

Decrease in vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Double vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Color blindness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Cataracts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Serious injury to eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No

EAR-NOSE-THROAT

Hearing loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Prolonged exposure to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Ringings in ears	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No

EAR-NOSE-THROAT (CONT.)	Yes	No	Don't Know	If yes, year of onset?	Still a problem? (Mark Yes or No)
Chronic ear infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Ruptured eardrum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Problematic snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Chronic sinus problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Allergic nasal symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Vocal cord polyp	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Chronic hoarseness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No

ENDOCRINE

Thyroid disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
High blood sugar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No

PULMONARY

Chronic cough or phlegm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Tuberculosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Chronic bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Pneumonia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Blood clot in lung	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Coughed up blood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Unexplained shortness of breath:					
While sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
While sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
With physical activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No

GASTROINTESTINAL

Fatty food intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Ulcer disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Frequent heartburn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No

IV. REVIEW OF SYSTEMS (CONT.)

GASTROINTESTINAL (CONT.)	Yes	No	Don't Know	If yes, year of onset?	Still a problem? (Mark Yes or No)
Vomited blood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Gallbladder trouble	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Abdominal pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Jaundice, hepatitis or cirrhosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Frequent diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Diarrhea caused by milk (lactose intolerance)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Blood in stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Tarry black stool	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Hemorrhoids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Colon Polyps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Chronic constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No

GENITOURINARY

Sexually transmitted diseases

–syphilis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
–gonorrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
–herpes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
–chlamydia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
–other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Sexual problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Decreased sex drive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Impotence (Men only)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
HIV positive/AIDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Blood in urine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Recurrent burning or pain during urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Recurrent kidney/bladder infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Difficulty urinating (starting or stopping)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Prostate trouble (Men only)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Awakening at night to urinate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Kidney stones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No

IV. REVIEW OF SYSTEMS (CONT.)

BONE AND JOINT	Yes	No	Don't Know	If yes, year of onset?	Still a problem? (Mark Yes or No)
Chronic joint or muscle pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Low back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Swollen/stiff joints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Gout	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Osteoporosis or decreased bone mass	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
NEUROPSYCHIATRIC					
Loss of consciousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Vertigo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Seizures or epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Frequent headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Treatment for nervous disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Numbness or tingling of arms, legs or face	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Difficulty sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Attention deficit disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Thoughts of suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Psychiatric or psychological counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
HEMATOLOGY					
Bleeding disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Enlarged lymph nodes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Previous blood transfusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
DERMATOLOGY					
Chronic skin rash	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Skin cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Shingles (herpes zoster)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No

IV. REVIEW OF SYSTEMS (CONT.)



DERMATOLOGY (CONT.)	Yes	No	Don't Know	If yes, year of onset?	Still a problem? (Mark Yes or No)
Skin sores that won't heal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Unusual moles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Breast lump	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Recurrent mouth sores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Nail fungus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Skin fungus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Psoriasis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No
Vitiligo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/> Yes <input type="radio"/> No

ALLERGIES AND IMMUNIZATIONS

- Have you had a tetanus booster in the last 10 years? Yes No
- Do you get yearly flu vaccines? Yes No
- Have you had a pneumonia vaccine (Pneumovax)? Yes No
- Have you completed a hepatitis vaccine series
(2 vaccines given in six months)? Yes No
- Have you completed a hepatitis B vaccine series
(3 vaccines given in six months)? Yes No
- Have you had any other recent immunizations?
(measles/mumps/rubella booster, polio, typhoid, yellow fever, Lyme disease) Yes No
- Do you frequently travel to any of these areas?
- Central/South America
 Asia
 Middle East
 India
 Africa
- Have you had a tuberculosis skin test (PPD or tine)? Yes No
- If yes, was it negative? Yes No

MEDICATIONS AND VITAMINS/SUPPLEMENTS

Do you take insulin? Yes No

List all CURRENT non-prescriptive medications and dosage
(include aspirin, oral contraceptives, over-the-counter medications, vitamins, diet supplements, etc.)

GYNECOLOGICAL HISTORY

When was your last menstrual period?

_____Month _____Day _____Year

When was your last pelvic examination?

_____Month _____Day _____Year

Was the pelvic examination abnormal? Yes No

Was the pap Smear abnormal? Yes No

Are you pregnant? Yes No

Are you currently using a form of birth control other than oral contraceptives? Yes No

Number of pregnancies? _____

Number of live births? _____

Your age at birth of first child? _____

Did you breastfeed any of your children for 3 months or longer? Yes No

At what age did you begin having menstrual periods? _____

Have you had your uterus removed? Yes No

Have you had your cervix removed? Yes No

Have you had both ovaries removed? Yes No

If yes, at what age? _____

Have you ever missed your periods for 3 months or longer? (excluding pregnancy) Yes No

Have you gone through menopause? (absence of period for 12 months) Yes No

BREAST HEALTH

When was your last breast examination by a physician?

_____Month _____Day _____Year

Do you examine your breasts for lumps each month? Yes No

Are you aware of any breast lumps? Yes No

IV. REVIEW OF SYSTEMS (CONT.)



BREAST HEALTH (CONT.)

Do you have any nipple discharge or bleeding? Yes No

Have you ever had breast x-rays (mammography) performed? Yes No

If yes, date? _____ Was it abnormal? Yes No

Have you ever had a breast biopsy? Yes No

Have you ever had any other breast surgery? Yes No

If yes, then what type? _____

V. PAST MEDICAL HISTORY

SIGNIFICANT ILLNESSES: Please list any other significant illnesses you had as a child or adult.

ILLNESS	YEAR(S)	PHYSICIAN'S COMMENTS

SIGNIFICANT SURGERIES: Please list, in chronological order, any surgeries you have had (both hospital and outpatient).

TYPE OF SURGERY	YEAR(S)	PHYSICIAN'S COMMENTS

V. PAST MEDICAL HISTORY (CONT.)



RADIATION TREATMENT: Please mark any radiation treatment that you have received to your head, neck, skin, or elsewhere. (Do not include diagnostic studies.)

AREA OF TREATMENT	DIAGNOSIS	YEAR	PHYSICIAN'S COMMENTS

DIAGNOSTIC STUDIES: Bubble in all of the following diagnostic studies you have had performed and indicate the year.

TEST	YEAR	PHYSICIAN'S COMMENTS
<input type="checkbox"/> ECG (Electrocardiogram)	_____	
<input type="checkbox"/> Treadmill stress test	_____	
<input type="checkbox"/> Nuclear heart scan	_____	
<input type="checkbox"/> Echocardiogram (ultrasound exam of the heart)	_____	
<input type="checkbox"/> Heart catheterization (dye test of the heart vessels)	_____	
<input type="checkbox"/> X-ray exam of stomach (upper GI series)	_____	
<input type="checkbox"/> Upper endoscopy	_____	
<input type="checkbox"/> X-ray exam of large intestine (barium enema)	_____	
<input type="checkbox"/> Proctoscopy or sigmoidoscopy (examination of the lowest portion of the colon with a flexible tube.)	_____	
<input type="checkbox"/> Colonoscopy	_____	
<input type="checkbox"/> Bone density	_____	
<input type="checkbox"/> Other	_____	

VI. FAMILY MEDICAL HISTORY

FATHER

HEALTH PROBLEMS (Mark all that apply)

AGE ONLY IF LIVING _____

OR

AGE AT DEATH _____

<input type="radio"/> Heart attacks, coronary bypass, angioplasty, or angina under age 50 (circle problem)	<input type="radio"/> Stroke	<input type="radio"/> High blood pressure
<input type="radio"/> Heart Attacks, coronary bypass, angioplasty, or angina age 50-65 (circle problem)	<input type="radio"/> Diabetes	<input type="radio"/> Osteoporosis
<input type="radio"/> High cholesterol or triglycerides	<input type="radio"/> Colon cancer	<input type="radio"/> Breast cancer
	<input type="radio"/> Lung cancer	<input type="radio"/> Other cancer

MOTHER

HEALTH PROBLEMS (Mark all that apply)

AGE ONLY IF LIVING _____

OR

AGE AT DEATH _____

<input type="radio"/> Heart attacks, coronary bypass, angioplasty, or angina under age 50 (circle problem)	<input type="radio"/> Stroke	<input type="radio"/> High blood pressure
<input type="radio"/> Heart Attacks, coronary bypass, angioplasty, or angina age 50-65 (circle problem)	<input type="radio"/> Diabetes	<input type="radio"/> Osteoporosis
<input type="radio"/> High cholesterol or triglycerides	<input type="radio"/> Colon cancer	<input type="radio"/> Breast cancer
	<input type="radio"/> Lung cancer	<input type="radio"/> Other cancer

BROTHERS/SISTERS

Provide information for each sibling.

HEALTH PROBLEMS (Mark all that apply)

SEX Male Female

AGE ONLY IF LIVING _____

OR

AGE AT DEATH _____

<input type="radio"/> Heart attacks, coronary bypass, angioplasty, or angina under age 50 (circle problem)	<input type="radio"/> Stroke	<input type="radio"/> High blood pressure
<input type="radio"/> Heart Attacks, coronary bypass, angioplasty, or angina age 50-65 (circle problem)	<input type="radio"/> Diabetes	<input type="radio"/> Osteoporosis
<input type="radio"/> High cholesterol or triglycerides	<input type="radio"/> Colon cancer	<input type="radio"/> Breast cancer
	<input type="radio"/> Lung cancer	<input type="radio"/> Other cancer

SEX Male Female

AGE ONLY IF LIVING _____

OR

AGE AT DEATH _____

<input type="radio"/> Heart attacks, coronary bypass, angioplasty, or angina under age 50 (circle problem)	<input type="radio"/> Stroke	<input type="radio"/> High blood pressure
<input type="radio"/> Heart Attacks, coronary bypass, angioplasty, or angina age 50-65 (circle problem)	<input type="radio"/> Diabetes	<input type="radio"/> Osteoporosis
<input type="radio"/> High cholesterol or triglycerides	<input type="radio"/> Colon cancer	<input type="radio"/> Breast cancer
	<input type="radio"/> Lung cancer	<input type="radio"/> Other cancer

VI. FAMILY MEDICAL HISTORY (CONT.)



BROTHERS/SISTERS (CONT.)

HEALTH PROBLEMS (Mark all that apply)

SEX Male Female
 AGE ONLY IF LIVING _____
 OR
 AGE AT DEATH _____

<input type="radio"/> Heart attacks, coronary bypass, angioplasty, or angina under age 50 (circle problem)	<input type="radio"/> Stroke	<input type="radio"/> High blood pressure
<input type="radio"/> Heart Attacks, coronary bypass, angioplasty, or angina age 50-65 (circle problem)	<input type="radio"/> Diabetes	<input type="radio"/> Osteoporosis
<input type="radio"/> High cholesterol or triglycerides	<input type="radio"/> Colon cancer	<input type="radio"/> Breast cancer
	<input type="radio"/> Lung cancer	<input type="radio"/> Other cancer

SEX Male Female
 AGE ONLY IF LIVING _____
 OR
 AGE AT DEATH _____

<input type="radio"/> Heart attacks, coronary bypass, angioplasty, or angina under age 50 (circle problem)	<input type="radio"/> Stroke	<input type="radio"/> High blood pressure
<input type="radio"/> Heart Attacks, coronary bypass, angioplasty, or angina age 50-65 (circle problem)	<input type="radio"/> Diabetes	<input type="radio"/> Osteoporosis
<input type="radio"/> High cholesterol or triglycerides	<input type="radio"/> Colon cancer	<input type="radio"/> Breast cancer
	<input type="radio"/> Lung cancer	<input type="radio"/> Other cancer

SEX Male Female
 AGE ONLY IF LIVING _____
 OR
 AGE AT DEATH _____

<input type="radio"/> Heart attacks, coronary bypass, angioplasty, or angina under age 50 (circle problem)	<input type="radio"/> Stroke	<input type="radio"/> High blood pressure
<input type="radio"/> Heart Attacks, coronary bypass, angioplasty, or angina age 50-65 (circle problem)	<input type="radio"/> Diabetes	<input type="radio"/> Osteoporosis
<input type="radio"/> High cholesterol or triglycerides	<input type="radio"/> Colon cancer	<input type="radio"/> Breast cancer
	<input type="radio"/> Lung cancer	<input type="radio"/> Other cancer

SEX Male Female
 AGE ONLY IF LIVING _____
 OR
 AGE AT DEATH _____

<input type="radio"/> Heart attacks, coronary bypass, angioplasty, or angina under age 50 (circle problem)	<input type="radio"/> Stroke	<input type="radio"/> High blood pressure
<input type="radio"/> Heart Attacks, coronary bypass, angioplasty, or angina age 50-65 (circle problem)	<input type="radio"/> Diabetes	<input type="radio"/> Osteoporosis
<input type="radio"/> High cholesterol or triglycerides	<input type="radio"/> Colon cancer	<input type="radio"/> Breast cancer
	<input type="radio"/> Lung cancer	<input type="radio"/> Other cancer

SEX Male Female
 AGE ONLY IF LIVING _____
 OR
 AGE AT DEATH _____

<input type="radio"/> Heart attacks, coronary bypass, angioplasty, or angina under age 50 (circle problem)	<input type="radio"/> Stroke	<input type="radio"/> High blood pressure
<input type="radio"/> Heart Attacks, coronary bypass, angioplasty, or angina age 50-65 (circle problem)	<input type="radio"/> Diabetes	<input type="radio"/> Osteoporosis
<input type="radio"/> High cholesterol or triglycerides	<input type="radio"/> Colon cancer	<input type="radio"/> Breast cancer
	<input type="radio"/> Lung cancer	<input type="radio"/> Other cancer

VI. FAMILY MEDICAL HISTORY (CONT.)



CHILDREN: Provide information for each child.

SEX	AGE ONLY IF LIVING	OR	AGE AT DEATH	HEALTH PROBLEMS
<input type="radio"/> Male <input type="radio"/> Female	_____		_____	_____
<input type="radio"/> Male <input type="radio"/> Female	_____		_____	_____
<input type="radio"/> Male <input type="radio"/> Female	_____		_____	_____
<input type="radio"/> Male <input type="radio"/> Female	_____		_____	_____

VII. PERSONAL HABITS

A. TOBACCO

1. Do you currently use tobacco? Yes No (skip to question 2)

a. If you smoke cigarettes now

How many per day? _____

What year did you start? _____

b. If you smoke cigars now

How many per day? _____

What year did you start? _____

c. If you smoke a pipe now

How many pipefuls per day? _____

What year did you start? _____

d. If you use "smokeless tobacco" now

How many times per day? _____

What year did you start? _____

2. Have you ever used tobacco? Yes No (skip to question 4)

3. Which of the following have you used in the past?

	How many per day?	What year did you start?	What year did you stop?
a. Cigarettes	_____	_____	_____
b. Cigars	_____	_____	_____
c. Pipe	_____	_____	_____
d. "Smokeless" Tobacco	_____	_____	_____

4. Are you exposed to secondhand smoke? Yes No

B. ALCOHOL

1. Do you drink alcoholic beverages? Yes No
 If yes, how many drinks per week?
 _____ Beer (12 oz.) _____ Wine (5 oz. glass) _____ Hard Liquor (1.5 oz)
2. Have you used alcohol in the past but subsequently quit? Yes No
3. Do you now have or have you ever had problems with excessive alcohol use? Yes No
4. If you drink alcoholic beverages.....
- a. Have you ever felt you ought to cut down on your drinking? Yes No
 - b. Have people annoyed you by criticizing your drinking? Yes No
 - c. Have you ever felt bad or guilty about your drinking? Yes No
 - d. Have you ever had a drink first thing in the morning to steady your nerves or get over a hangover? Yes No
 - e. Has your drinking ever affected your job or ability to work? Yes No
 - f. Have you ever been arrested for driving while intoxicated or under the influence of alcohol? Yes No

C. DRUGS

1. Have you ever used or do you currently use recreational drugs? Yes No

D. WEIGHT

1. What do you consider a good weight for yourself?
 _____pounds
2. What was your highest weight after age 18 (excluding pregnancy)?
 _____pounds _____at what age?
3. What was your lowest weight after age 18?
 _____pounds _____at what age?
4. What was your weight at age 21?
 _____pounds
5. Weight loss history: How many times in your life would you estimate you have lost the number of pounds shown below?
- _____5 lbs. _____10 lbs. _____20 lbs. _____30 lbs. _____50 lbs.
 _____80 lbs. _____100 lbs.+

VII. PERSONAL HABITS (CONT.)



E. DIET

1. Are you currently on any diet or dietary restriction? Yes (mark all types below) No

- Low Fat
- Low Sodium (salt)
- Low Calorie (weight reduction)
- High Fiber
- Low Cholesterol
- Other (Specify): _____

2. How long have you been following the diet? _____

F. MEALS

1. In an average week, how many meals (out of 21) do you eat out? _____

G. BEVERAGES: Give the number of servings that you consume in an average week of the following:

Water (glasses) _____

Coffee (cups) _____

- Regular
- Decaffeinated

Tea (cups) _____

- Regular
- Decaffeinated or Herbal

Soft Drinks (12oz) _____

- Regular (with sugar)
- Sugar Free

How many of the above soft drinks contain caffeine? _____

VIII. EXERCISE

A. GENERAL EXERCISE

1. Do you currently participate in any type of exercise? Yes No

2. How many days per week do you exercise (on average)? _____ Days

a. What was the longest period that you were continuously exercising?

_____ Years _____ Months _____ Weeks

b. What was the longest period that you were not exercising?

_____ Years _____ Months _____ Weeks

3. How many total years have you been exercising regularly? _____ Years

B. AEROBIC ACTIVITIES: For the last three months, which of the following activities have you performed? (Please mark YES for all that apply and No if you do not perform the activity. Provide an estimate amount of activity for all marked YES.)

1. Walking Yes No (skip to next activity)

WALKING (CONT.)

- a. How many workouts per week? _____
- b. How many miles (or fractions) per workout? _____
- c. Average duration of workout? _____ Minutes
2. Jogging or Running O Yes O No (skip to next activity)
- a. How many workouts per week? _____
- b. How many miles (or fractions) per workout? _____
- c. Average duration of workout? _____ Minutes
3. Bicycling (outdoors) O Yes O No (skip to next activity)
- a. How many workouts per week? _____
- b. How many miles (or fractions) per workout? _____
- c. Average duration of workout? _____ Minutes
4. Stationary Cycling O Yes O No (skip to next activity)
- a. How many workouts per week? _____
- b. Average durations of workout? _____ Minutes
5. Swimming Laps O Yes O No (skip to next activity)
- a. How many workouts per week? _____
- b. How many miles (or fractions) per workout? _____
(880 yards = 0.5 miles)
- c. Average duration of workout? _____ Minutes
- d. How many months per year? _____
6. Aerobic Dance or Floor Exercises O Yes O No (skip to next activity)
- a. How many workouts per week? _____
- b. Average duration per workout? _____ Minutes
7. Vigorous Sports O Yes O No (skip to next activity)
(e.g. Racquetball, Singles Tennis, Skating)
- a. Please specify: _____
- b. How many workouts per week? _____
- c. Average duration per workout? _____ Minutes
8. Other Activity O Yes O No
- a. Type: _____
- b. How many workouts per week? _____
- c. Average duration per workout? _____ Minutes

C. MUSCLE STRENGTHENING ACTIVITIES

1. Are you currently involved in a muscle strengthening program? Yes (mark all that apply) No (skip to section D)
- Calisthenics Free Weights Weight Training Machines Other (specify)
- a. How many days per week do you do these exercises? _____
- b. Average duration of workout? _____ Minutes
- c. For what length of time? _____ Years _____ Months _____ Weeks
- d. Which of the following best describes your muscle strengthening routine?

Upper Body (mark one)

- Low weights with low repetitions (<12 reps)
- Low weights with high repetitions (≥ 12 reps)
- High weights with low repetitions (<12 reps)
- High weights with high repetitions (≥ 12 reps)

Lower Body (mark one)

- Low weights with low repetitions (<12 reps)
- Low weights with high repetitions (≥ 12 reps)
- High weights with low repetitions (<12 reps)
- High weights with high repetitions (≥ 12 reps)

D. FLEXIBILITY ACTIVITIES

1. Are you currently involved in exercises to maintain or improve your joint flexibility? Yes No
- a. What type of exercises? (Mark all that apply)
- Stretching Calisthenics Exercise Class Yoga
- b. How many days per week do you do these exercises? _____
- c. Average duration of exercise? _____ Minutes
- d. How long have you been involved in this routine? _____ Years _____ Months

IX. STRESS AND EMOTIONAL FACTORS

1. How stressful do you consider your home life to be? Low Moderate High
2. How stressful do you consider your occupation to be? Low Moderate High
3. How would you classify yourself on the following tension and anxiety scale?
- No tension, very relaxed Slight tension Moderate tension
- High tension Very tense, "high-strung"

4. What is your greatest source of worry or concern at present?

- Marriage Family Job Finances Health Other

5. How well do you feel you manage your stress?

- Not well most of the time Fairly well most of the time Very well most of the time

6. Do stress and tension in your life seem to cause you to have any of the following symptoms? (Mark all that apply)

- General irritability or impatience Headache Abdominal discomfort
 Sleeplessness Fatigue Other: _____

7. How often do you use medications, alcohol, or other substances to help you relieve stress and relax?

- Frequently (several times a week) Seldom (once or twice a month)
 Occasionally (once or twice a week) Almost never

8. Please rate your general emotional outlook on life on the following scale:

- Often Very Depressed Generally Sad Happy & Sad Equal Amount
 Generally Happy Usually Very Happy and Optimistic

9. How do you rate your overall health? Poor Fair Good Excellent

Please indicate how often you have felt this way during the past week. (Mark only one answer per question)

10. Were you bothered by things that usually don't bother you?

- 5-7 days
 3-4 days
 1-2 days
 less than 1 day

11. Did you have trouble keeping your mind on what you were doing?

- 5-7 days
 3-4 days
 1-2 days
 less than 1 day

12. Did you feel depressed?

- 5-7 days
 3-4 days
 1-2 days
 less than 1 day

13. Did you feel that everything you did was an effort?

- 5-7 days
- 3-4 days
- 1-2 days
- less than 1 day

14. Did you feel hopeful about the future?

- 5-7 days
- 3-4 days
- 1-2 days
- less than 1 day

15. Did you feel fearful?

- 5-7 days
- 3-4 days
- 1-2 days
- less than 1 day

16. Was your sleep restless?

- 5-7 days
- 3-4 days
- 1-2 days
- less than 1 day

17. Were you happy?

- 5-7 days
- 3-4 days
- 1-2 days
- less than 1 day

18. Did you feel lonely?

- 5-7 days
- 3-4 days
- 1-2 days
- less than 1 day

19. Did you feel you could not get "going"?

- 5-7 days
- 3-4 days
- 1-2 days
- less than 1 day

