**Attachment D2**

**Medical History**

Form Approved

OMB No. 0920-xxxx

Exp. Date xx/xx/20xx

**II. Medical History**

1. In general, would you say your health is:

 [ ]  (1) Excellent

 [ ]  (2) Very good

 [ ]  (3) Good

 [ ]  (4) Fair

 [ ]  (5) Poor

2. Compared to your last visit to UB, how would you rate your health in general now?

 [ ]  (1) Much better now than at last visit

 [ ]  (2) Somewhat better now than at last visit

 [ ]  (3) About the same

 [ ]  (4) Somewhat worse now than at last visit

 [ ]  (5) Much worse now than at last visit

3. What was your weight one year ago? \_\_\_\_\_\_\_ pounds

4. How long has it been since you last saw a physician for any reason (approximately)?

 [ ]  (1) Within the last 1 year

 [ ]  (2) 1 to 3 years ago

 [ ]  (3) 3 to 5 years ago

 [ ]  (4) More than 5 years ago

5. How often do you have a routine physical examination, that is, an exam by a doctor or health care professional,

 not for a particular illness, but for a general checkup?

 [ ]  (1) Do not have routine physical examinations

 [ ]  (2) Less than once every five years

 [ ]  (3) At least once every five years

 [ ]  (4) At least once every year

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6. Have you been told by a doctor or health care professional that you have **high blood pressure**?

 [ ]  (0) No [ ]  (1) Yes [ ]  (3) Don’t Know

 If **NO** or **Don’t Know**, go to Question 7

1. If **YES**, how old were you when you were first told by a medical professional that you had high blood pressure?

 \_\_ \_\_ years old. [ ]  (93) Don’t Know

 B. For women only: If **YES**, did this condition exist only when you were pregnant?

 [ ]  (0) No [ ]  (1) Yes [ ]  (3) Don’t Know [ ]  (8) Not Applicable

 C. Are you currently being treated for high blood pressure?

 [ ]  (0) No [ ]  (1) Yes [ ]  (3) Don’t Know

 D. If you are being treated for high blood pressure, do you currently take:

 [ ]  (10) Maxzide [ ]  (27) Lisinopril

 [ ]  (13) Zestril [ ]  (33) Diovan

 [ ]  (17) HCTZ [ ]  (44) Diovan HCT

 [ ]  (18) Atenolol [ ]  (36) Lotrel

 [ ]  (20) Accupril [ ]  (37) Toprol, Toprol XL

 [ ]  (21) Norvasc [ ]  (47) Metoprolol

 [ ]  (24) Verapamil [ ]  (87) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Have you been told by a doctor or health care professional that you have **high cholesterol**?

 [ ]  (0) No [ ]  (1) Yes [ ]  (3) Don’t Know

 If **NO** or **Don’t Know**, go to Question 8

1. If **YES**, how old were you when you were first told by a medical professional that you had high cholesterol?

 \_\_ \_\_ years old. [ ]  (93) Don’t Know

 B. Are you currently being treated with medication for high cholesterol?

 [ ]  (0) No [ ]  (1) Yes [ ]  (3) Don’t Know

 C. If you are being treated for high cholesterol, do you currently take:

 [ ]  (1) Lipitor [ ]  (22) Vytorin

 [ ]  (10) Lovastatin [ ]  (24) Simvastatin

 [ ]  (20) Crestor [ ]  (87) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you been told by a doctor or health care professional that you have **high or elevated sugar** in blood or urine?

 [ ]  (0) No [ ]  (1) Yes [ ]  (3) Don’t Know

 If **NO** or **Don’t Know**, go to Question 9

A. If **YES**, how old were you when you were first told by a medical professional that you had elevated sugar in blood or urine?

 \_\_ \_\_ years old. [ ]  (93) Don’t Know

9. Have you been told by a doctor or health care professional that you have **diabetes**?

 [ ]  (0) No [ ]  (1) Yes [ ]  (3) Don’t Know

 If **NO** or **Don’t Know**, go to Question 10

1. If **YES**, Was this [ ]  (1) Insulin Dependent Diabetes (Type 1) or

 [ ]  (2) Non-Insulin Dependent Diabetes (Type 2)

1. If **YES**, how old were you when you were first told by a medical professional that you had diabetes?

 \_\_ \_\_ years old. [ ]  (93) Don’t Know

C. If **YES**, what type of treatment are you taking for your diabetes?

 [ ]  (1) insulin injections [ ]  (4) by exercise

 [ ]  (2) oral hypoglycemic agent (pill) [ ]  (5) by doing nothing

 [ ]  (3) by dietary control [ ]  (6) other

1. If you are taking an oral hypoglycemic agent (pill), for diabetes, do you currently take:

 [ ]  (1) Glucotrol [ ]  (13) Metformin

 [ ]  (2) Diabinese [ ]  (16) Glyburide

 [ ]  (4) Glucophage [ ]  (17) Avandamet

 [ ]  (10) Avandia [ ]  (87) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 E. For women only: **If YES**, did this condition exist only when you were pregnant?

 [ ]  (0) No [ ]  (1) Yes [ ]  (3) Don’t Know [ ]  (8) Not Applicable

10. If you have been told by a doctor or health care professional that you have or have had any of the listed conditions, please check "Yes" and fill in the other items. Check "No" if you have never been told that you have the condition.

|  | **Condition** |  **No** (0) |  **Yes** (1) | **If Yes,****Age First Diagnosed** |
| --- | --- | --- | --- | --- |
| 1 | **Angina** (chest pain related to your heart) | 🞎No | 🞎Yes | \_\_ \_\_ |
|  | If yes, was the angina confirmed by angiogram? | 🞎No🞎Don't  Know | 🞎Yes |  |
| 2 | **Heart attack** (myocardial infarction, MI) | 🞎No | 🞎Yes | \_\_ \_\_ |
|  |  Number of times this occurred \_\_\_\_\_\_\_\_ |  |  |  |
| 3 | **Atrial fibrillation** (special type of irregular heart beat) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 4 | **Irregular heart beat** (arrhythmia) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 5 | **Diseased heart valve** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 6 | **Rheumatic heart disease** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 7 | **Congestive heart failure** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 8 | **Stroke** | 🞎No | 🞎Yes | \_\_ \_\_ |
|  |  Number of times this occurred \_\_\_\_\_\_\_\_ |  |  |  |
| 9 | **Transient ischemic attack** (T.I.A., ”mini-stroke”) | 🞎No | 🞎Yes | \_\_ \_\_ |
|  |  Number of times this occurred \_\_\_\_\_\_\_\_ |  |  |  |
| 10 | **Peripheral vascular disease** (intermittent claudication or leg pain on exercise, but not varicose veins) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 11 | **Deep venous thrombosis** (blood clots in your legs, but not varicose veins) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 12 | **Aortic aneurysm** (thinning in the wall of the big artery going to the heart) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 13 | **Pulmonary embolus** (blood clot in the lung) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 14 | **Childhood asthma** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 15 | **Lung problems as a child** (e.g. multiple cases of pneumonia or bronchitis) Please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎No | 🞎Yes | \_\_ \_\_ |
| 16 | **Asthma as an adult** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 18 | **Chronic bronchitis** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 19 | **Emphysema** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 20 | **Pneumonia** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 21 | **Tuberculosis** (TB) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 22 | **Pleurisy** (inflammation of the lining of the lungs)  | 🞎No | 🞎Yes | \_\_ \_\_ |
| 23 | **Fibrotic lung disease** (Fibrosis) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 24 | **COPD** (Chronic Obstructive Pulmonary Disease) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 25 | **Other chronic lung disease**: (Please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎No | 🞎Yes | \_\_ \_\_ |
| 26 | **Gall bladder disease** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 27 | **Kidney or bladder stones** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 28 | **Kidney disease** (Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 29 | **Jaundiced** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 30 | **Hepatitis** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 31 | **Liver cirrhosis** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 32 | **Polyps in your colon or rectum** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 33 | **Broken bones as an adult** (includes stress fractures) | 🞎No | 🞎Yes |  |
|  |  **If yes, please specify which bone and age at time of fracture:** **Bone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_**  **Bone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_** **Bone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_** **Bone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_** |  |  |  |
| 34 | **Osteoporosis** (thinning bones) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 35 | **Osteoarthritis** (degenerative joint disease) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 36 | **Rheumatoid arthritis** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 37 | **Systemic lupus erythematosus** (Lupus) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 38 | **Polymyalgia** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 39 | **Sarcoidosis** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 40 | **Other immune disease** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 41 | **Thyroid disease** **Hyperthyroidism** 🞎 **Hypothyroidism** 🞎 **Don’t Know** 🞎 | 🞎No | 🞎Yes | \_\_ \_\_ |
| 42 | **Parathyroid disease** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 43 | **Seizures** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 44 | **Depression** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 45 | **Any neurologic disease** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 46 | **Benign breast disease**(non-cancerous, includes fibrocystic breast disease, fibroids, cystic breast or mastitis) | 🞎No | 🞎Yes | \_\_ \_\_ |
| 47 | **Cancer In-Situ** (localized cancer that does not usually spread)Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎No | 🞎Yes | \_\_ \_\_ |
| 48 | **Skin cancer** | 🞎No | 🞎Yes | \_\_ \_\_ |
| 49 | **Any other type of cancer, not skin cancer** (Please describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎No | 🞎Yes | \_\_ \_\_ |
| 50 | **Are you currently undergoing treatment for cancer?**If YES, what type of treatment? Chemotherapy Radiation therapy Hormone therapy Other (Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | 🞎No🞎No🞎No🞎No🞎No | 🞎Yes🞎Yes🞎Yes🞎Yes🞎Yes |  |
| 51 | **Have you had any other disease** (Please describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎No | 🞎Yes | \_\_ \_\_ |

This next question deals with medical procedures which you may have had. For each item, check "Yes" if you have had the procedure, "No" if not. If you check "Yes", please write in the date of your most recent procedure.

|  | **Procedure** |  **No** (0)  |  **Yes** (1)  | **Most Recent Year** |
| --- | --- | --- | --- | --- |
| 1 | **EKG/ECG** (electrical tracing of heart's activity) | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 2 | **Echocardiogram** (ultrasound of the heart and its chambers) | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 3 | **Stress test** (such as an exercise stress test) | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 4 | **Doppler test** (an ultrasound of blood vessels) | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 5 | **Angiogram or cardiac catheterization** (heart catheterization or coronary angiogram) | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 6 | **Carotid endarterectomy** (opening of blockage or narrowing of the arteries in your neck) | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 7 | **Clot dissolving treatment** to prevent or reduce heart attack (sometimes called TPA or streptokinase therapy) | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 8 | **Atherectomy** (sometimes referred to as "roto-rooter") | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 9 | **Angioplasty** of coronary arteries (opening arteries of the heart with a balloon- sometimes called PTCA) | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 10 | **Stent inserted** | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
|  | **If yes, location of stent: Coronary artery** **Carotid artery** | 🞎No🞎No | 🞎Yes🞎Yes | \_\_\_\_\_\_\_\_\_\_\_\_ |
| 11 | **Heart bypass surgery** or coronary bypass surgery for blocked or clogged arteries | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 12 | **Heart valve repair/replacement** | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 13 | **Pacemaker** | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 14 | **Bronchoscopy** (exam of your lungs with a small scope) | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 15 | **Colonoscopy** (exam of your colon with a small scope) | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 16 | **Bone Density Test** | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
| 17 | **Chest x-ray** | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
|  | If yes, about how many **chest x-rays** have you had in your life: \_\_\_\_\_\_ |  |  |  |
| 18 | **X-ray of the spine or back** (to see curvature of the spine) | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
|  | If yes, about how many **back x-rays** have you had in your life: \_\_\_\_\_\_ |  |  |  |
| 19 | **Dental x-ray** | 🞎No | 🞎Yes | \_\_\_\_\_\_ |
|  | If yes, about how many **dental x-rays** have you had in your life: \_\_\_\_\_\_ |  |  |  |
| 20 | **Other x-ray/radiation treatment** (not diagnostic)Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎No | 🞎Yes | \_\_\_\_\_\_ |