

Attachment D2

Medical History

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

A. 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:

- | | |
|---|---|
| <input type="checkbox"/> (10) Maxzide | <input type="checkbox"/> (27) Lisinopril |
| <input type="checkbox"/> (13) Zestril | <input type="checkbox"/> (33) Diovan |
| <input type="checkbox"/> (17) HCTZ | <input type="checkbox"/> (44) Diovan HCT |
| <input type="checkbox"/> (18) Atenolol | <input type="checkbox"/> (36) Lotrel |
| <input type="checkbox"/> (20) Accupril | <input type="checkbox"/> (37) Toprol, Toprol XL |
| <input type="checkbox"/> (21) Norvasc | <input type="checkbox"/> (47) Metoprolol |
| <input type="checkbox"/> (24) Verapamil | <input type="checkbox"/> (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

A. 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:

- | | |
|--|---|
| <input type="checkbox"/> (1) Lipitor | <input type="checkbox"/> (22) Vytorin |
| <input type="checkbox"/> (10) Lovastatin | <input type="checkbox"/> (24) Simvastatin |
| <input type="checkbox"/> (20) Crestor | <input type="checkbox"/> (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

A. If **YES**, Was this

(1) Insulin Dependent Diabetes (Type 1) or

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

B. 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

D. 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) If yes, was the angina confirmed by angiogram?	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	___
2	Heart attack (myocardial infarction, MI) Number of times this occurred _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
3	Atrial fibrillation (special type of irregular heart beat)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
4	Irregular heart beat (arrhythmia)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
5	Diseased heart valve	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
6	Rheumatic heart disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
7	Congestive heart failure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
8	Stroke Number of times this occurred _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
9	Transient ischemic attack (T.I.A., "mini-stroke") Number of times this occurred _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
10	Peripheral vascular disease (intermittent claudication or leg pain on exercise, but not varicose veins)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
11	Deep venous thrombosis (blood clots in your legs, but not varicose veins)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
12	Aortic aneurysm (thinning in the wall of the big artery going to the heart)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
13	Pulmonary embolus (blood clot in the lung)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
14	Childhood asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
15	Lung problems as a child (e.g. multiple cases of pneumonia or bronchitis) Please describe: _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
16	Asthma as an adult	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
18	Chronic bronchitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
19	Emphysema	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
20	Pneumonia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___

	Condition	No (0)	Yes (1)	If Yes, Age First Diagnosed
21	Tuberculosis (TB)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
22	Pleurisy (inflammation of the lining of the lungs)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
23	Fibrotic lung disease (Fibrosis)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
24	COPD (Chronic Obstructive Pulmonary Disease)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
25	Other chronic lung disease: (Please describe) _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
26	Gall bladder disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
27	Kidney or bladder stones	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
28	Kidney disease (Specify _____)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
29	Jaundiced	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
30	Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
31	Liver cirrhosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
32	Polyps in your colon or rectum	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
33	Broken bones as an adult (includes stress fractures)	<input type="checkbox"/> No	<input type="checkbox"/> 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)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
35	Osteoarthritis (degenerative joint disease)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
36	Rheumatoid arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
37	Systemic lupus erythematosus (Lupus)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
38	Polymyalgia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
39	Sarcoidosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
40	Other immune disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
41	Thyroid disease Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Don't Know <input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
42	Parathyroid disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
43	Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___

	Condition	No (0)	Yes (1)	If Yes, Age First Diagnosed
44	Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —
45	Any neurologic disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —
46	Benign breast disease (non-cancerous, includes fibrocystic breast disease, fibroids, cystic breast or mastitis)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —
47	Cancer In-Situ (localized cancer that does not usually spread) Where: _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —
48	Skin cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —
49	Any other type of cancer, not skin cancer (Please describe): _____ _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —
50	Are you currently undergoing treatment for cancer? If YES, what type of treatment? Chemotherapy Radiation therapy Hormone therapy Other (Please specify _____)	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	
51	Have you had any other disease (Please describe): _____ _____	<input type="checkbox"/> No	<input type="checkbox"/> 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)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
2	Echocardiogram (ultrasound of the heart and its chambers)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
3	Stress test (such as an exercise stress test)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
4	Doppler test (an ultrasound of blood vessels)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
5	Angiogram or cardiac catheterization (heart catheterization or coronary angiogram)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
6	Carotid endarterectomy (opening of blockage or narrowing of the arteries in your neck)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
7	Clot dissolving treatment to prevent or reduce heart attack (sometimes called TPA or streptokinase therapy)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
8	Atherectomy (sometimes referred to as "roto-rooter")	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
9	Angioplasty of coronary arteries (opening arteries of the heart with a balloon- sometimes called PTCA)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
10	Stent inserted If yes, location of stent: Coronary artery Carotid artery	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	_____ _____ _____
11	Heart bypass surgery or coronary bypass surgery for blocked or clogged arteries	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
12	Heart valve repair/replacement	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
13	Pacemaker	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
14	Bronchoscopy (exam of your lungs with a small scope)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
15	Colonoscopy (exam of your colon with a small scope)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
16	Bone Density Test	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
17	Chest x-ray If yes, about how many chest x-rays have you had in your life: _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
18	X-ray of the spine or back (to see curvature of the spine) If yes, about how many back x-rays have you had in your life: _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
19	Dental x-ray If yes, about how many dental x-rays have you had in your life: _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
20	Other x-ray/radiation treatment (not diagnostic) Reason: _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____