

## **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

Public reporting burden of this collection of information is estimated to average 8 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

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.

	<b>Condition</b>	<b>No</b> (0)	<b>Yes</b> (1)	<b>If Yes, Age First Diagnosed</b>
1	<b>Angina</b> (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	<b>Heart attack</b> (myocardial infarction, MI)  Number of times this occurred _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
3	<b>Atrial fibrillation</b> (special type of irregular heart beat)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
4	<b>Irregular heart beat</b> (arrhythmia)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
5	<b>Diseased heart valve</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
6	<b>Rheumatic heart disease</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
7	<b>Congestive heart failure</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
8	<b>Stroke</b>  Number of times this occurred _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
9	<b>Transient ischemic attack</b> (T.I.A., "mini-stroke")  Number of times this occurred _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
10	<b>Peripheral vascular disease</b> (intermittent claudication or leg pain on exercise, but not varicose veins)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
11	<b>Deep venous thrombosis</b> (blood clots in your legs, but not varicose veins)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
12	<b>Aortic aneurysm</b> (thinning in the wall of the big artery going to the heart)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
13	<b>Pulmonary embolus</b> (blood clot in the lung)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
14	<b>Childhood asthma</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
15	<b>Lung problems as a child</b> (e.g. multiple cases of pneumonia or bronchitis) Please describe:  _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
16	<b>Asthma as an adult</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
18	<b>Chronic bronchitis</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
19	<b>Emphysema</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___
20	<b>Pneumonia</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	___

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

	<b>Condition</b>	<b>No</b> (0)	<b>Yes</b> (1)	<b>If Yes, Age First Diagnosed</b>
44	<b>Depression</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —
45	<b>Any neurologic disease</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —
46	<b>Benign breast disease</b> (non-cancerous, includes fibrocystic breast disease, fibroids, cystic breast or mastitis)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —
47	<b>Cancer In-Situ</b> (localized cancer that does not usually spread) Where: _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —
48	<b>Skin cancer</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —
49	<b>Any other type of cancer, not skin cancer</b> (Please describe): _____ _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —
50	<b>Are you currently undergoing treatment for cancer?</b> 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	<b>Have you had any other disease</b> (Please describe): _____ _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	— —

