TRANSPORTATION SECURITY OFFICER MEDICAL QUESTIONNAIRE

PUBLIC BURDEN and PRIVACY ACT STATEMENTS

PUBLIC BURDEN STATEMENT: TSA is collecting this information to determine suitability to serve as a TSO. This is a voluntary collection of information; however, failure to furnish the requested information may result in an inability to consider your eligibility for employment as a TSO. TSA estimates that the total average burden per response associated with this collection is approximately 1.65 hours, including the time for reviewing instructions, getting needed information, travel time to receive the necessary medical screening, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing burden, to the U.S. Office of Personnel Management (OPM), Strategic Human Resources Policy, Medical Policy and Programs Division, Attn: OMB Number (1652-0032), 1900 E Street, NW, Washington, D.C. 20415. The OMB number control number assigned to this collection of information is 1652-0032, which will expire on 7/31/2023. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number.

PRIVACY ACT STATEMENT: AUTHORITY: 49 U.S.C. 44935 PRINCIPAL PURPOSE(S): This information will be used to determine your eligibility for employment as a Transportation Security Officer (TSO). ROUTINE USE(S): This information may be shared with contractors, grantees, or volunteers performing or working on a contract, service, grant, cooperative agreement, or job for the federal government, or for routine uses identified in the Office of Personnel Management's system of records notice, OPM/GOVT-10 Employee Medical File System Records (if hired) or OPM/GOVT-5 Recruiting, Examining, and Placement Records (if not hired). DISCLOSURE: Voluntary; failure to furnish the requested information may result in an inability to consider your application for employment.

INSTRUCTIONS

It is required that you personally complete each question or response in this questionnaire. After completing each page, record your initials in the space provided at the bottom of each page and print and sign your name on the last page. Your responses will be reviewed with you by a medical professional.

It is recommended that you review the TSO Medical Guidelines prior to taking the medical assessment. The medical guidelines can be found at https://jobs.tsa.gov/Resources/TSO_Medical_Guidelines.pdf. Consider bringing medical records/documentation regarding any chronic diseases or medical conditions, such as recent lab reports or stress test results to your medical exam appointment. For purposes of this examination, please do not include any genetic information, including family medical history or the results of any genetic testing, with any medical records/ documentation you provide. NOTE TO MEDICAL EXAMINER: Please do not collect any genetic information provided

DEMOGRAPHIC INFORMATION

Name (Print):	**Last 4 of Social Security #:** XXX - XX - ______
Address:	
City, State, Zip	**Sex: Male** _______ **Female** _______
Primary Phone #: (_________) ______________	**Date of Birth:**
Secondary Phone #: (_________) ______________	**(mm / dd / yyyy)**
Other Phone#: ______________	**Height: Feet** _____ **Inches** _____ **Weight** __________
Best Time to Call:	

GENERAL INFORMATION

1. Have you been refused employment, dismissed from a job, or unable to stay in school due to any medical condition or excessive absenteeism? 1. YES ______NO _____

   If YES, please list each medical condition and the year of the refusal/dismissal:
   1. ________________________________ MO/YR__________
   2. ________________________________ MO/YR__________
   3. ________________________________ MO/YR__________

2. Have you had any operations and/or medical procedures? 2. YES ______NO _____

   If YES, describe and indicate date:
   1. ________________________________ MO/YR__________
   2. ________________________________ MO/YR__________
   3. ________________________________ MO/YR__________

3. Have you had a visit to a clinic, physician, chiropractor, ER, urgent care, outpatient facility, physical therapist, healer, acupuncturist, or any other practitioner within the past year? 3. YES ______NO _____

   If YES, specify condition and healthcare provider consulted, and indicate date:
   1. ________________________________ MO/YR__________
   2. ________________________________ MO/YR__________
   3. ________________________________ MO/YR__________

GENERAL INFORMATION (continued)

4. Are you currently taking any **prescription** medications? 4. YES _____NO _____
If YES, complete box below. If medication is "as needed" specify approximate frequency. Use back of paper as needed.

NAME OF MEDICATION	REASON FOR MEDICATION	DOSE	FREQUENCY: HOW OFTEN DO YOU TAKE EACH (daily, nightly, etc.)?	DATE OF LAST DOSE

5. Are you currently taking any **non- prescription OTC** medications/herbs/supplements? 5. YES _____NO _____
If YES, complete box below. If medication is "as needed" specify approximate frequency. Use back of paper as needed.

NAME OF MEDICATION	REASON FOR MEDICATION	DOSE	FREQUENCY: HOW OFTEN DO YOU TAKE EACH (daily, nightly, etc.)?	DATE OF LAST DOSE

EXAMINER COMMENTS – GENERAL INFORMATION:

Examiner MUST enter a comment on all positive history / "yes" answers. Ensure all sections of medication tables are complete.

VISION and HEARING

6. Do you have known uncorrectable vision loss or a total loss of vision in either eye? … …………………… 6. YES _____NO_____
   If YES, indicate date of onset: ……………………………………………………. Date: MO/YR_________
7. Have you had any type of refractive eye surgery such as LASIK, PRK, etc.? ……………………………… 7. YES _____NO______
   If YES, answer below:
   a. Type of surgery: ____ Date: MO/YR_________
   b. Do you have any dryness that affects your vision?............................ YES _______NO _______
   c. Do you use steroid eye drops? …………………………………………...YES _______NO _______
8. Do you use a hearing aid for either ear?... 8. YES _____NO ______

EXAMINER COMMENTS – VISION and HEARING:

Examiner MUST enter a comment on all positive history / "yes" answers.

RESPIRATORY

9. Do you have asthma?.. 9. YES ______NO ______

10. Do you have chronic obstructive pulmonary disease (COPD)?.. 10. YES ______NO ______

11. Do you have blood in sputum when coughing?.. 11. YES ______NO ______

12. Have you EVER had active tuberculosis (not just a positive skin test)? ……………………………………… 12. YES ______NO ______

If YES, answer the questions below:

a. When was your last Chest X-Ray?.. Date: MO/YR_________

b. When were you treated?.. Date: MO/YR_________

c. How long was your treatment? ____

13. Have you ever had any other lung disease?...13. YES ______NO ______

If YES, specify disease: ____

EXAMINER COMMENTS – RESPIRATORY:

Examiner MUST enter a comment on all positive history / “yes” answers.

CARDIOVASCULAR

Have you ever had or experienced any of the following?

14. Hypertension? …………………………………………………………………………………………………… 14. YES ______NO _____

If YES, answer the questions below and **Go to APPENDIX A at the end of this document to provide complete information**:

a. Have you had a treadmill exercise stress test? ……………………………YES ______NO _____

If **YES**, date of most recent? ………………… MO/YR______________________________

Was it normal? ………………………………… YES ______NO ______ Don’t know _____

What METS did you reach? ……..……………___________________ Don’t know _____

b. Have you had any complications of hypertension, such as, stroke, coronary artery disease, left ventricular hypertrophy, atrial fibrillation, heart failure, nephropathy, retinopathy, or aortic aneurysm? YES ______NO ______

List the complication(s): ____

Complete APPENDIX A at the end of this document.

15. Coronary artery disease, heart attack, open heart surgery, stent, or angioplasty? ……………………….. 15. YES ______NO _____

If YES, answer the questions below:

a. Indicate MO/YR or Not applicable (NA):

Heart attack ____________ Open heart surgery ___________ Stent or angioplasty __________

b. Have you had a treadmill exercise stress test with imaging?.................. YES _____NO ______

Date of most recent? ………………………… MO/YR______________________________

Was it normal? ………………………………… YES ______NO ______ Don’t know _____

What METS did you reach? ..…………………___________________ Don’t know _____

c. Do you have chest pain with exertion or activity? ……………………….. YES ______NO ______

d. Are your risk factors being treated (smoking, hypertension, cholesterol, obesity, etc.)? YES ______NO ______

e. When was your last heart medication change? ……………………….. MO/YR _______________

f. Have you been compliant with treatment? ……………………………….. YES ______NO _____

CARDIOVASCULAR (continued)

16. Heart failure? ……….. 16. YES ______NO ______

If YES, answer the question below:

a. Have you had an echocardiogram, or stress echocardiogram? ……….. YES ______NO ______

If YES, indicate the ejection fraction if known: ………………………….. ______ % Don't know ______

17. Cardiomyopathy? ……………………………………………………………………………………………… 17. YES ______NO ______

18. Atrial fibrillation, atrial flutter, supraventricular tachycardia, Wolff-Parkinson-White Syndrome or ventricular tachycardia? …… 18. YES ______NO ______

If YES, answer the questions below:

a. Did you have an ablation? ………………………………………………… YES ______NO ______

Date(s) of ablation? ………………………………………………………… MO/YR ____________

Was it successful? …………………………………………………………… YES ______NO ______

b. Have you had an echocardiogram, or stress echocardiogram? ……….. YES ______NO ______

If YES, indicate the ejection fraction if known: ………………….. ______ % Don't know ______

c. Have you had a treadmill exercise stress test with imaging? …………….YES ______NO ______

Date of most recent? …………………………………………………… MO/YR______________

Was it normal? ………………………………………… YES ______NO ______ Don't know ______

What METS did you reach? ………………………….. ______________ Don't know ______

19. Ventricular fibrillation? ……………………………………………………………………………………...19. YES ______NO ______

20. Unexplained syncope (fainting or passing out)? ……………………………………………………………...20. YES ______NO ______

If YES, date of last occurrence: ……………………………........................... MO/YR ________________

21. Pacemaker? ………………………………………………………………………………………………..…..21. YES ______NO ______

22. Valvular heart disease? …………………………………………………………………………………………22. YES ______NO ______

If YES, specify type: ____

23. Automatic implantable cardiac defibrillator (AICD)?..……………………………………………………… 23. YES ______NO ______

24. Peripheral vascular disease that causes pain with walking? ………………………………………………….. 24. YES ______NO ______

25. Thoracic or abdominal aortic aneurysm? …..……………………………………………………………………25. YES ______NO ______

26. Other cardiac condition(s) not previously mentioned? ………………………………………………………..26. YES ______NO ______

Please explain: ____

EXAMINER COMMENTS – CARDIOVASCULAR:

Examiner MUST enter a comment on all positive history / "yes" answers.

If history of heart failure or cardiomyopathy, what is the NYHA classification, I II III IV:

ABDOMINAL ORGANS and RENAL

27. Have you had or do you currently have a hernia? .... 27. YES ______NO ______

If YES, answer questions below:

a. Circle type: inguinal ventral umbilical femoral
b. Has it been repaired? .... YES ______NO ______
c. Do you have pain, restrictions, or limitations? .... YES ______NO ______

If YES, specify limitations/restrictions: ____

28. Do you have chronic kidney disease (CKD)? .... .28. YES ______NO ______

If YES, answer the questions below:

a. What is the stage? (circle response) 1 2 3 4 5 Don't Know
b. What is your most recent GFR? _____________mL/min MO/YR ___________ Don't Know ______

29. Are you being treated with hemodialysis or peritoneal dialysis? .... 29. YES ______NO ______

EXAMINER COMMENTS – ABDOMINAL ORGANS and RENAL:

Examiner MUST enter a comment on all positive history / "yes" answers.

MUSCULOSKELETAL

Have you ever had or experienced any of the following?

30. Amputation or congenitally absent body part?.. 30. YES ______NO ______

If YES, answer below:

a. Specify body part:____
b. Do you use any prosthesis? .... YES ______ NO _______

31. Do you use any ambulatory aids (crutches, cane, walker, etc.)? .... 31. YES ______NO ______

If YES, specify: ____

32. Upper extremity condition (hand, wrist, forearm, elbow, upper arm, shoulder)? .... 32. YES ______NO ______

If YES, specify: ____

33. Lower extremity condition (foot, ankle, lower leg, knee, upper leg, hip)? .... 33. YES ______NO ______

If YES, specify: ____

34. Spine condition (back, neck, surgery)? .... 34. YES ______NO ______

If YES, specify: ____

35. Joint replacement surgery? .... 35. YES ______NO ______

If YES, provide details and dates: ________________________________MO/YR _______________

EXAMINER COMMENTS – MUSCULOSKELETAL:

Examiner MUST enter a comment on all positive history / "yes" answers. If examinee has current and temporary physical restrictions (lift, squat, bend, reach overhead, walk, stand, etc.) document how long the restrictions are expected to last; if not known please state.

NEUROLOGICAL

Have you **ever** had or experienced any of the following:

36. Cerebrovascular accident (CVA, stroke, brain bleed, or TIA)? ……………………………………………….36. YES ______NO ______

If YES, answer below:

a. Specify type and date: ________________________________ MO/YR _______________

b. Do you have any residual physical, mental, or emotional impairments or limitations? YES ______NO ______

If YES, explain: ____

37. Seizures?…………………………………………………………………………………………………..37. YES ______NO ______

If YES, answer the questions below:

a. Do you have epilepsy?.. YES ______NO ______

b. What causes your seizures? ________________________________ Don't Know _________

c. Date of last seizure? …………………………………………………. MO/YR _______________

d. Date of last evaluation by a neurologist? …………………………….. MO/YR _______________

38. Vertigo? ………………………………………………………………………………………………… 38. YES ______NO ______

If YES, specify date of last occurrence: ………………………………….. MO/YR _______________

39. Meniere's disease? ………………………………………………………………………………… 39. YES ______NO ______

40. Paralysis of a limb? ………………………………………………………………………………… 40. YES ______NO ______

41. Complete loss of touch sensation in upper extremity? ………………………………………………… 41. YES ______NO ______

42. Cognitive impairment (ongoing memory loss, dementia)? …………………………………………….... 42. YES ______NO ______

43. Malignancy of the spinal cord or brain? ……………………………………………………………….... 43. YES ______NO ______

44. Amyotrophic lateral sclerosis? ……………………………………………………………………….... 44. YES ______NO ______

45. Multiple sclerosis? ……………………………………………………………………………………… 45. YES ______NO ______

If YES, answer questions below:

a. Specify date of diagnosis: ……………………………………………. MO/YR _______________

b. Specify date of last relapse: ………………………………………….. MO/YR _______________

c. Do you have a mood disorder? ……..……………………………….. YES _______NO _______

46. Parkinson's? ……………………………………………………………………………………………. 46. YES ______NO ______

47. Other neurologic disorder not previously noted? ………………………………………………………….. 47. YES ______NO ______

If YES, specify: ____

EXAMINER COMMENTS –NEUROLOGICAL:

Examiner MUST enter a comment on all positive history / "yes" answers.

ENDOCRINE

48. Do you have diabetes? ………………………………………………………………………………………….. 48. YES ______NO ______

If YES, answer questions (a) through (o) below and **Go to APPENDIX A at the end of this document to provide complete information**:

a. Are you compliant with your prescribed treatment? ……………………….YES ______NO ______

b. Have you had an episode(s) of hypoglycemia requiring the help of others in the past three years? ………………………………………………………………………………….. YES ______NO ______

If YES, specify details and dates:

1. ____
2. ____

c. Have you had diabetic ketoacidosis in the past 12 months? ………..… YES ______NO ______

d. What was your last hemoglobin A1c? … __________________ %   Don't know ______________

e. When was your last hemoglobin A1c? ……………………….…………….. MO/YR ______________

f. Have you completed diabetes education? ……………………………….. YES ______NO ______

g. Do you self-monitor your blood glucose? …………………………………. YES ______NO ______

h. Do you have lightheadedness with standing? …..……………..………… YES ______NO ______

i. Do you have peripheral neuropathy that interferes with your activity? ... YES ______NO ______

If YES, explain: ____

j. Do you have chronic kidney disease (CKD)? …………..………………….. YES ______NO ______

If YES, specify GFR __________________mL/min   Don't know ________________

k. Have you had a dilated eye exam? …………..……………………….……YES ______NO ______

If YES, specify last exam date:..……………………..……………….. MO/YR ______________

l. Do you have retinopathy? ……………………….……………………………. YES ______NO ______

m. Do you have type 1 diabetes treated with insulin?......................................YES ______NO ______

If YES, any change in insulin regimen in the past 6 months? ……… YES ______NO ______

n. Do you have type 2 diabetes treated with insulin? …..…………………….....YES ______NO ______

If YES, any change in insulin regimen in the past 3 months…….........YES ______NO ______

o. Do you have type 2 diabetes treated with non-insulin medication? …...... YES ______NO ______

If YES, any change in medication in the past 30 days? ……………...... YES ______NO ______

Complete APPENDIX A at the end of this document.

EXAMINER COMMENTS – Endocrine:

Examiner MUST enter a comment on all positive history / "yes" answers.

SLEEP DISORDERS

Have you ever had or experienced any of the following:

49. Narcolepsy? ………………………………………………………………………………………………… 49. YES ______NO ______
    If YES, is it with cataplexy? …………..……………………………………….………… YES ______NO ______
50. Obstructive sleep apnea? ……………………………………………………………………….………… 50. YES ______NO ______
    If YES, answer questions below:
    a. Did you have a sleep study? ………..…………………………….………… YES ______NO ______
       If YES, What symptoms were you having that prompted the sleep study? (circle all that apply)
       Daytime sleepiness   Snoring   Insomnia
       Nocturnal awakenings/not breathing   Other ____________
    b. Were you prescribed treatment with CPAP? ……….…………………… YES ______NO ______
       If YES, How many days/wk do you wear your CPAP? ________ How many hrs/night? _______
    (If you have a recent CPAP compliance report, please provide to examiner)
51. Shift work disorder? …………………………………………………………………………………... 51. YES ______NO ______
52. **If YES** to narcolepsy, sleep apnea, or shift work disorder, what are your current symptoms from these conditions?

____

EXAMINER COMMENTS – SLEEP DISORDERS:

Examiner MUST enter a comment on all positive history / "yes" answers.

PSYCHOLOGICAL

Have you ever had or experienced any of the following:

53. Anxiety disorder? ……………………………………………………………………………………… 53. YES ______NO ______
    If YES, date of last occurrence of symptoms? ……………………………………... MO/YR ______________
54. Panic attack? ……………………………………………………………………………………………… 54. YES ______NO ______
    If YES, date of last panic attack? ……………..………………………………… MO/YR ______________
55. Social anxiety disorder? ………………………………………………………………………………… 55. YES ______NO ______
    If YES, date of last occurrence of symptoms? ……………………………………… MO/YR ______________
56. Attention deficit/hyperactivity disorder (ADHD)? ……………………………………………..…… 56. YES ______NO ______
    If YES, date of last occurrence of symptoms? ……………………………………… MO/YR ______________
57. Bipolar disorder? …………………………………………………………………………………….. 57. YES ______NO ______
    If YES, did you ever have a manic episode?.. YES ______NO ______
58. Depressive disorder? ………………………………………………………………………..………… 58. YES ______NO ______
    If YES, date of last occurrence of symptoms? ……..………………………………. MO/YR ______________
59. Personality disorder? …………………………………………………………………….……… 59. YES ______NO ______
60. Post-traumatic stress disorder (PTSD)? ……………………………………………………….…… 60. YES ______NO ______
    If YES, date of last occurrence of symptoms? ……………..…………………………. MO/YR ______________

PSYCHOLOGICAL (continued)

61. Psychosis or psychotic features? ………………………………………………………………………… 61. YES ______NO ______

62. Substance use disorder? ……………………………………………………………………………………… 62. YES ______NO ______

If YES, answer the questions below:

a. What substance(s)? ____

b. Date of last use? ………………………………………………………….. MO/YR _______________

c. Have you completed a substance use disorder treatment program?…… YES ______NO _______

63. Are you being treated for a mental health condition? ………………………………………………………. 63. YES ______NO ______

If YES, answer the questions below:

a. Are you treated by a psychologist or psychiatrist? ……………………… YES ______NO ______

If **YES**, when was your last visit?...MO/YR _____________

b. Are you compliant with your treatment

(medications, follow-up appointments, referrals)? ………………………..YES ______NO ______

Date of last treatment ………………………………………………………. MO/YR _____________

c. Do you have any sedating side effects from your treatment? ……………YES ______NO ______

d. Do you have irritability? ……………………………………………………..YES ______NO ______

e. Do you have difficulty concentrating? ……………………………………...YES ______NO ______

f. Do you have any diagnosed phobias? ……………………………………YES ______NO ______

g. Has your condition ever interfered with your job or daily activities?.........YES ______NO ______

If **YES**, when was the last time your condition interfered with your job or activities? MO/YR _____________

Please explain:____

64. Suicide attempt? ……………………………………………………………………………………………….. 64. YES ______NO ______

If YES, date: ……………………………………………………………………………….. MO/YR _____________

65. Electroconvulsive therapy? …………………………………………………………………………………… 65. YES ______NO ______

If YES, date of last ECT therapy: ………………………………………………………….. MO/YR _____________

66. Schizophrenia, schizoaffective, or schizophreniform disorder? …………………………………………… 66. YES ______NO ______ .

67. Other mental health disorder not previously noted? ………………………………………………………... 67. YES ______NO ______

If YES, specify: ____

EXAMINER COMMENTS – PSYCHOLOGICAL:

Examiner MUST enter a comment on all positive history / "yes" answers.

ACTIVITY

68. Answer the questions below regarding your ability. Are you able to:

Frequently lift and carry passenger baggage weighing up to 50 pounds without assistance?...............ABLE ______UNABLE ______

Frequently squat, bend and stoop?.. ABLE ______UNABLE ______

Frequently reach overhead with each arm? ..……………………………………………………………… ABLE ______UNABLE ______

Stand continuously for up to 4 hours without a break? ……………………………………………………..ABLE ______UNABLE ______

Walk for up to 3 miles during a shift? ………………………………………………………………………….ABLE ______UNABLE ______

Feel and manipulate small objects with both hands? ……..………………………………………….……...ABLE ______UNABLE ______

Open/close zippers, snaps, and buckles on baggage, backpacks, or briefcases? ………………………ABLE ______UNABLE ______

ACTIVITY (continued)

What is your present activity level? Circle the level of activity listed below that best describes how often you participate in each of the activities:

Activity	**Never/Rarely** 0 to 2 times per year	**Occasionally** 1 to 2 times per month	**Frequently** Once per week or more
Walk 2 miles continuously	Never/Rarely	Occasionally	Frequently
Run 2 miles continuously	Never/Rarely	Occasionally	Frequently
Weight training /general fitness activity at gym	Never/Rarely	Occasionally	Frequently
Team sports (basketball, football, soccer, etc.)	Never/Rarely	Occasionally	Frequently
Gardening / yard work	Never/Rarely	Occasionally	Frequently
Golf	Never/Rarely	Occasionally	Frequently
Winter sports (skiing, ice skating, etc.)	Never/Rarely	Occasionally	Frequently
Swimming / cycling	Never/Rarely	Occasionally	Frequently
Other (list):	Never/Rarely	Occasionally	Frequently

69. Do you have any restrictions or limitations on your activity or function? ……………………………………………69. YES ______NO ______

    If YES, explain in detail: ____

70. Do you have anything additional to report that has not already been addressed? ……………………………..70. YES ______NO ______

    If YES, explain: ____

EXAMINER COMMENTS – ADDITIONAL COMMENTS:

Examiner MUST enter a comment on all positive history / "yes" answers.

CANDIDATE SIGNS BELOW after reading the following statements:

I certify that I have reviewed the foregoing information supplied by me and it is true and complete to the best of my knowledge. I have read the privacy statement at the beginning of this questionnaire and understand that falsification, misrepresentation or omission of information on Government forms is punishable by fine and/or imprisonment and/or may be grounds for disqualification from TSA employment, or disciplinary or adverse action if employed.

The exam information collected from your appointment for your TSO pre-placement physical will be forwarded to TSA's primary medical contractor, Acuity-Comprehensive Health Services (CHS). Acuity-CHS is the sole authority for rendering TSO medical qualification determinations and they will contact you directly if they have any questions or need any further information to make an eligibility determination.

REQUIRED Candidate Printed Name ____

Date (mm/dd/yyyy)

REQUIRED **Candidate Signature** ____

FACILITY PROVIDER/EXAMINER (MD, DO, PA, or NP) SIGNS BELOW:

REQUIRED Examiner Printed Name ____

Date (mm/dd/yyyy)

REQUIRED **Examiner Signature** ____ MD, DO, PA, NP (circle one)

APPENDIX A

Candidate Name: ______________________________________

If you have a history of Diabetes or Hypertension, complete the following for the purpose of calculating your ASCVD (atherosclerotic cardiovascular disease) risk score according to the American Heart Association and American College of Cardiology. This published formula requires the following information to calculate your ASCVD risk score per the TSO Medical Guidelines: current age, sex, race, systolic blood pressure, total cholesterol, HDL cholesterol, history of diabetes, smoking, and treatment for hypertension. If you know the following information, please circle the correct response and enter the values below:

Race (circle one): White African American Other

Total Cholesterol (mg/dL): ________________ Approximate MO/YR ___________ Don't know ____________

HDL Cholesterol (mg/dL): ________________ Approximate MO/YR ___________ Don't know ____________

Smoker (circle one): Yes Former No

How long ago did you quit? ________________________

Previous editions of this form are obsolete.