SubID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Screening Questionnaire-N

INSTRUCTIONS: In order to ensure that you can safely participate in this study, we need to have some information regarding the current and past status of your health and related problems. Please answer the questions below by checking the appropriate blank alongside the item and/or by using the space provided to supply the necessary information. All data will be kept strictly confidential. If you need more space, use the backs of the pages, identifying each extended response with the number of the question.

1. Have you ever had any of the following conditions (check all that apply and explain):
2. Head injury, seizures or loss of consciousness? \_\_\_\_\_
3. Severe or persistent headaches? \_\_\_\_\_
4. Dizziness? \_\_\_\_\_
5. Vision problems (other than simple near- or far-sightedness) or glaucoma? \_\_\_\_\_
6. Hearing problems \_\_\_\_\_
7. Severe or persistent muscle weakness (myasthenia)? \_\_\_\_\_
8. Asthma or other respiratory problems? \_\_\_\_\_
9. Heart condition, high blood pressure, or other cardiovascular condition? \_\_\_\_\_
10. Diabetes, hypoglycemia, or other blood-sugar problems? \_\_\_\_\_
11. Ulcer or other gastrointestinal problem? \_\_\_\_\_
12. Liver or kidney problem? \_\_\_\_\_
13. Thyroid problems?

2. Have you taken any prescription or over-the-counter medications in the last year?

\_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, indicate the name of the medication, the reason, dose, and duration for each use, and the date each was last taken.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Reason for use | Dose per day | Duration (weeks) | Date of last use |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

3. Are you now, or have you in the last year, been under the care of a physician or other health professional for any medical condition? \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, indicate the nature of the condition or diagnosis, if known, and the type and date(s) of any treatment and its outcomes. (use back of page, if needed)

|  |  |  |  |
| --- | --- | --- | --- |
| Health Condition or Diagnosis | Treatment | Treatment dates | Outcome |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

4. What brand of cigarettes do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke everyday? No Yes

How many cigarettes do you smoke per day?

How long have you smoked at your current level?

How many cigarettes have you smoked today?

When did you smoke your last cigarette? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ a.m. or p.m. Date Time (circle one)

Do you use any other form of nicotine (e.g. chewing tobacco, nicotine replacement products)?

No Yes If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Are you currently pregnant? No Yes