**The Raine Study Gen2:28 year Vision and Vessels**

**Follow up**

**Participant Medical Questionnaire**

Date..............................................

ID Number.....................................

Thank you for taking the time to fill in this questionnaire.

Please read each question carefully and answer ALL of the questions

All information will be strictly confidential

The purpose of this questionnaire is to obtain information about any diagnosed conditions and health problems you may have now or experienced in the past, as well as your health service utilisation and use of any prescription or over the counter medications.

If you have any questions or information please ask the Research Assistant or please contact the Raine Study on:

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**1. MEDICATIONS**

The following questions are about your health and medical history, doctor-prescribed medications, over-the-counter medications or supplements you may take.

**1.1 Do you currently take medication(s) prescribed by a doctor?**

* No *(Please go to* ***Q1.2****)*
* Yes, If yes, please list all **PRESCRIBED** medications you currently take, e.g. Coversyl, Lipitor, mini pill, medicinal marijuana/cannabis use

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| Medication | Condition which the medication is prescribed for | Dose in mgs | Frequency  e.g. daily,  twice a day | How long have you been taking this medication at the current dose?  (Years or months?) |
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**1.2 Over the counter medications**

**Have you taken any non-prescription medications in the last 3 months? (E.g. paracetamol, ibuprofen, aspirin etc.)**

* No *(Please go to* ***Q1.4****)*
* Yes, please list

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| Medication | Condition which you took the medication for | Dose in mgs | Frequency  e.g. daily,  twice a day | When did you last have this medication |
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**1.3 Vitamins, supplements or other substances**

**Do you currently take supplements or substances (e.g. anabolic agents, peptides, beta-blockers, stimulants) that have not been prescribed by a doctor for the purpose of** -

**Enhancing your performance in an important area of your life such as work, study, or sport (e.g. anabolic agents, peptides, beta-blockers, stimulants)?**

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| **a.** Name of substance or supplement (or product) | Dose in mgs | Frequency (e.g. daily, weekly) | How long have you been taking this substance or supplement (Years and months)? |
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No *(Please go to* ***b****)*  Yes *(Please complete* ***a***)

Losing weight (e.g. diuretics, stimulants)?

* No *(Please go to* ***c****)*  Yes *(Please complete* ***b***)

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| **b.** Name of substance or supplement (or product) | Dose in mgs | Frequency (e.g. daily, weekly) | How long have you been taking this substance or supplement (yrs and mths)? |
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Building muscles (e.g. growth hormones, steroids, protein powder, creatine, pre-workout)?

* No *(Please go to* ***d****)*  Yes *(Please complete* ***c***)

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| **c.** Name of substance or supplement (or product) | Dose in mgs | Frequency (e.g. daily, weekly) | How long have you been taking this substance or supplement (yrs and mths)? |
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Improving your general health or well-being (e.g. fish oil, calcium, VitB, VitC etc)

* No *(*Females *Please go to* ***Q1.4*** *males go to* ***2.0*** *)* Yes *(Please complete* ***d***)

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| **d.** Name of substance or supplement (or product) | Dose in mgs | Frequency (e.g. daily, weekly) | How long have you been taking this substance or supplement (yrs and mths)? |
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# **2.0. MEDICAL HISTORY**

We are interested in knowing your recent medical history and any major illness you may have had.

**2.1 CARDIOVASCULAR DISEASE: In the last 5 years have you had one of the following conditions that were diagnosed by a health professional (even if initially diagnosed longer than 5 years ago)?**

*(Please select all that apply)*

* Angina
* Arrhythmia such as AVT or atrial fibrillation
* Claudication (problems with blood supply to your legs that causes pain on walking)
* High blood pressure
* High cholesterol
* Implant or cardiac pacemaker
* Myocardial infarction/ Heart attack
* Transient ischemic attack (TIA)
* Stroke
* Carotid surgery (endarterectomy or stent)
* Coronary angioplasty or stent
* Coronary bypass
* Other *(please specify*)…………………………………………….
* None of the above

*If Yes* ***- please enter year diagnosed (e.g. 2010)***

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| Comments *(Q2.1)* |  |  |
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| OFFICE USE ONLY: **Q2.1** |  | | |
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| **.2** |  | **.5**  |  |
| **.3** |  | .6  |  |

**2.2 ENDOCRINE DISEASE**: **In the last 5 years have you had one of the following conditions that were diagnosed by a health professional (even if initially diagnosed longer than 5 years ago)?**

*(Please select all that apply)*

* Polycystic ovary syndrome
* Endometriosis
* Osteoporosis
* Kidney disease
* Thyroid disease
* Other *(please specify*)………………………………………………………………..
* None of the above

*If Yes* ***- please enter year diagnosed (e.g. 2010)***

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| Comments *(Q2.2)* |  |  |
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**2.3 NEUROLOGICAL CONDITIONS: In the last 5 years have you had one of the following conditions that were diagnosed by a health professional (even if initially diagnosed longer than 5 years ago)?**

*(Please select all that apply)*

* Alzheimer’s disease
* Vascular dementia (Multi-infarct dementia)
* Parkinson’s disease
* Attention Deficit (Hyperactivity) Disorder
* Anxiety disorder (including Post Traumatic Stress Disorder)
* Bipolar disorder
* Schizophrenia
* Epilepsy
* Chronic Fatigue (ME)
* Depression
* Other *(please specify*)……………………………………………………………..
* None of the above

*If Yes-* ***please enter diagnosed (eg.2010)***

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| Comments *(Q2.3)* |  |  |
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**2.4 ALLERGIES AND RESPIRATORY DISEASE: In the last 5 years have you had one of the following conditions that were diagnosed by a health professional (even if initially diagnosed longer than 5 years ago)?**

*(Please select all that apply)*

* Asthma or bronchial asthma
* Eczema
* Bronchitis
* Chronic obstructive pulmonary disease (COPD)
* Hay fever or allergic rhinitis
* Pleurisy
* Pneumonia
* Sinusitis
* Other *(please specify)………………………………………………………..*
* None of the above

*If Yes-* ***please enter diagnosed (eg.2010)***

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| Comments *(Q2.4)* |  |  |
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**2.5 AUTOIMMUNE DISEASE: In the last 5 years have you had one of the following conditions that were diagnosed by a health professional (even if initially diagnosed longer than 5 years ago**)?

*(Please select all that apply)*

* Ankylosing Spondylitis
* Multiple sclerosis
* SLE (lupus)
* Other *(please specify)……………………………………………………………..*
* None of the above

*If Yes-* ***please enter diagnosed (eg.2010)***

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| Comments *(Q2.5)* |  |  |
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**2.6 DIABETES: Has a doctor ever diagnosed you with diabetes?**

* No *(Please go to Sleep problems* ***Q2.7****)*
* Yes

**2.6A What kind of diabetes were you diagnosed with?**

* Type 1 diabetes (also known as insulin dependent diabetes)
* Type 2 diabetes (also known as non-insulin dependent diabetes)

*If Yes* ***- please enter year diagnosed (e.g. 2010)***

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| Comments *(Q2.6A)* |  |  |
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**2.7 SLEEP PROBLEMS: In the last 5 years have you had one of the following conditions that were diagnosed by a health professional (even if initially diagnosed longer than 5 years ago)?**

*(Please select all that apply)*

* Obstructive sleep apnoea
* Narcolepsy
* Loud or disruptive snoring
* Insomnia disorder
* Excessive (too much) sleepiness
* Restless legs or periodic leg movements of sleep
* Other please specify………………………………………………………….
* None of the above

*If Yes* ***- please enter year diagnosed (e.g. 2010)***

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**2.8 GASTROINTESTINAL DISORDERS: In the last 5 years have you had one of the following conditions that were diagnosed by a health professional (even if initially diagnosed longer than 5 years ago)?**

*(Please select all that apply)*

* Stomach (gastric) or duodenal ulcer
* Colon cancer
* Colonic polyps
* Coeliac disease
* Gastro-oesophageal reflux disease
* Hiatus Hernia
* Crohn’s disease
* Ulcerative colitis (or proctitis)
* Irritable bowel syndrome
* Diverticular disease
* Gallstones
* Haemorrhoids
* Other (please specify)……………………………………
* None of the above

*If Yes* ***- please enter year diagnosed (e.g. 2010)***

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| Comments *(Q2.8)* |  |  |
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**2.9 MUSCULOSKELETAL DISORDERS: In the last 5 years have you had one of the following conditions that were diagnosed by a health professional (even if initially diagnosed longer than 5 years ago)?**

*(Please select all that apply)*

* Neck condition (e.g. neck pain, nerve impingement)
* Back condition (e.g. back pain, prolapsed disc)
* Shoulder condition (e.g. shoulder pain, rotator cuff tear, shoulder bursitis)
* Hip condition (e.g. hip pain, hip osteoarthritis, hip impingement)
* Knee condition (e.g. knee pain, knee osteoarthritis, kneecap problems)
* Other (please specify)………………………………………………………………………
* None of the above

*If Yes* ***- please enter year diagnosed (e.g. 2010)***

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| Comments *(Q2.9)* |  |  |
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| **.3** |  | **.4**  |

**2.10 Have you been diagnosed with cancer?**

* No *(Please go to Other medical conditions)*
* Yes

**2.11 What type of cancer(s) were you diagnosed with?** *(Please select all that apply)*

* Breast Cancer
* Prostate Cancer
* Skin Cancer
* Bowel Cancer
* Lung Cancer
* Blood cancer
* Lymphoma
* Other (please specify)

*If Yes* ***– please enter year diagnosed (e.g .2010) and if a PRIMARY cancer.***

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| Comments *(Q2.11)* |  |  |
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| **.3** | **.4**  |  |

**2.12 OTHER MEDICAL CONDITIONS: In the last 5 years have you had one of the following conditions that were diagnosed by a health professional (even if initially diagnosed longer than 5 years ago)?**

*(Please select all that apply)*

* Alcoholic hepatitis
* Chronic ear infection
* Ménières Disease
* Trauma to the head or neck
* Anaemia
* Arthritis
* Migraine
* Headache
* Cirrhosis of the liver
* Fatty liver
* Poliomyelitis
* Urinary tract infection
* Hearing loss *(please describe*)…………………………………………………….
* Disease of the eye (*please describe)…………………………………………*
* Other major medical condition(s) – please list below
* No other major medical conditions

*If yes to other major medical conditions -* ***Please list and enter year diagnosed (eg.2010)***

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**3. ACCIDENTS INJURIES OR HOSPITAL ADMISSION**

**3.1 In the past 5 years, have you had any accidents or injuries which required you to go to a doctor (GP), hospital or clinic?**

* No *(Please go to* ***Q3.2****)*
* Yes

Please describe the accident, the injury and any treatment (e.g. broken leg from playing football) and list every accident or injury separately, giving as much detail as possible

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| **Injury** | **How did it happen?** | **When did it happen?** | **Treatment** |
| Eg. Sprained wrist | Fell down stairs | 2 years ago | Physiotherapy |
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| **OFFICE USE ONLY: (Q3.1)** |
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| **.3.4** |

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| **.5.6** |
| **.7.8** |

**3.2 In the past 5 years, have you been admitted to a hospital or day surgery?**

* No *(Please go to* ***Q3.3****)*
* Yes

**Please list each admission separately, giving as much detail as possible.**

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| **Date** | **Which hospital** | **Reason for admission** |
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| **OFFICE USE ONLY: (Q3.2)** |
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| .2**--** |
| .3**--** |
| .4**--** |

**3.3 Approximately how many times have you seen the following health professionals about your health in the last 12 months?**

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|  | **0** | **1** | **2** | **3** | **4** | **5** | **6-10** | **11 +** |
| GP or family doctor | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Accident and Emergency | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Hospital outpatient (department or clinic) | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Private medical specialist | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Dentist, dental therapist, orthodontist | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Optician/optometrist | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Dietician/nutritionist | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Physiotherapist | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Occupational therapist (OT) | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Speech therapist | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Psychologist/psychiatrist | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Podiatrist | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Chiropractor | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Alternative therapist e.g. iridologist | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Audiologists | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |
| Other (please specify)  …………………………………………………………………… | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 | 🗆 |

**THANKYOU for completing this questionnaire**

**Please give to the Research Assistant or return to the Raine Study**