			For Office Use Only					
			Date of Birth					
	w minutes to fill out this qu							
you can. If you need to chang	ge an answer, completely e ss otherwise instructed. Plea Shade circles like	rase the incorrect nase do not mark out	mark and fill in the correct circle. Mark only one side of the circle or make stray marks. 3 5 7 For optimum accuracy, please avoid					
	Not like this:	edical History	contact with the outline of boxes.					
107		· · · · · · · · · · · · · · · · · · ·						
1.0 In general, do you thin	nk your nealth is:		e diagnosed with skin cancer, what type Mark all that apply)					
© Excellent								
○ Very Good ○ Good		○ Basal cel	ll carcinoma					
ି Fair		○ Melanon	na					
○ Poor		ି Squamot	is cell carcinoma					
1.1 Have you ever had an	y of the following?	○ Don't know						
(Mark all that apply)		1.4 Have you ever been told that you have diabetes?						
○ Asthma			•					
© Cerebrovascular dise	ase (stroke)	⊃ Yes	□ No (lf 'No', go to question 1.7)					
○ Congestive heart fail	ure	1.5 Do you take insulin?						
O Dysplastic nevi (funi	ıy looking mole)							
○ Heart disease		○ Yes	○ No					
○ Hepatitis B		1 6 D	-!4					
○ High cholesterol		1.6 Do you mo	mitor your blood sugar at home?					
○ Hypertension (high b ○ Kidney failure	olood pressure)	○ Yes	○ No					
Obstructive lung dise (emphysema, chronic		1.7 Have you ever had any of the following procedures? (Mark all that apply)						
Osteoporosis (brittle	bones)	○ Cardiac o	catheterization					
 Prostate disease 		Cardiac s	surgery					
© Tuberculosis		○ Pacemak	er or defibrillator insertion					
None from this list		Prostate !	biopsy or surgery					
1.2 Have you ever had an cancers? (Mark all tha	-	○ Removal	or freezing of an actinic keratosis caly patch on skin)					
Colon cancer	Skin cancer	· -	of dysplastic nevi (or funny looking mole)					
C Lung cancer	Other cancer	of the ski	n					
Prostate cancer	Never had cancer	ncer I haven't had any of these procedures						
Prostate cancer	Never had cancer	1 l haven't	had any of these procedures					

Please continue on the next page...



Name (Last, First, Middle Initial)

1.8 Do you use any assistive devices? (Mark all that apply)	1.10 Do you regularly take any of the following: (Mark all that apply)				
© Eye glasses or contact lenses	○ Aspirin				
○ Hearing aid(s)	○ Melatonin				
○ Oxygen	○ Saw palmetto				
○ Walker	○ Selenium				
○ Wheelchair	Other herbal or health supplements				
○ Other	I take no herbal or health supplements				
© I use no assistive devices	i r				
1.9 Do you currently take (prescription,	1.11 How much do you weigh?				
over-the-counter, or sample) medication for any of the following? (Mark all that apply)	pounds				
○ Asthma					
○ Cancer	1.12 How tall are you?				
○ Cerebrovascular disease (stroke)					
○ Depression	feet inches				
○ Diabetes	1 12 In the last 6 months, have you goined an last				
○ Heart disease	1.13 In the last 6 months, have you gained or lost 10 or more pounds without dieting?				
○ High blood pressure	F				
○ High cholesterol	○ Yes				
○ Osteoporosis	○ No				
O Prostate disease					
O None from this list					
Some people have a higher risk of certain diseases. We can help you understand your risk if you tell us about your family.					

Family History										
	Fathe	r's Fa	mily	Moth	er's l	Family	<u> </u>	our]	Famil	iv
If your blood relative(s) had or have the following health conditions, please fill in the circle under that relative. (Mark all that apply)	Grandfather	Grandmother	Father	Grandfather	Grandmother	Mother	Sister(s)	Brother(s)	Daughter(s)	Son(s)
2.0 Heart disease, heart attack or angina?	0	\circ	0		0	0	0	0	0	0
2.1 Diabetes ?	Ĵ	\circ	\circ	ļ O	0	0	\circ	C,	<u> </u>	0
2.2 High blood pressure or stroke?	0	0	0		0	0 }	0	0	C	0
2.3 Colon or rectal cancer?	Ç	0	\circ		0	0	0	0	Э	\circ
2.4 Melanoma skin cancer?	0	0	0	; 0	0	0 ;	0	\circ	\circ	0
2.5 Prostate cancer?	5		0	. 0				C:		O
2.6 Other cancer?	0	\circ	0		0	0 ;	\circ	\subset	_	\circ

Please continue on the next page...

36644

101 -

205000

Adult Male Health Overview

© 2000 PhDx Systems, Inc All Rights Reserved

○ I have red or blonde hair

I have fair skin

○ I have blue or green eyes

None of these apply to me

3.15 When you need to make health decisions, where

(Mark all that apply)

Doctors

Family

Friends

○ Internet

Magazines or newspapers

O SCCIPA On Call Advice line

Television or radio

○ Other

Please continue on the next page...



101 -

205000





When did you last have the following:

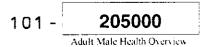
		Less than	1-2	3-5	6-9		I
		12 months	years	years	years	10 or more	don't
	Never	ago	ago	ago	ago	years ago	know
3.16 Blood pressure measured	0	Ĉ	C	C	()		5
3.17 Cholesterol measured	\circ	Ĉ	0	\circ	\circ	0	0
3.18 Dental checkup	\circ	Ĵ	\circ	0	Ç	Ĉ	C ·
3.19 Diabetes test	0	Э	0	\circ	0	0	<u> </u>
3.20 Electrocardiogram (ECG)	0	5	0	C	0	÷.	Ĵ
3.21 Fecal occult or stool blood test	0	Э	0	C	0	9	0
3.22 Flex sigmoidoscopy (colon exam)	0	0	0	C	\supset	<u></u>	-
3.23 Flu shot	0	Э	0	C.	0	0	C
3.24 Pneumovax or pneumonia vaccine	0	<u> </u>	0	0	0	Ĵ	-
3.25 Prostate exam or digital rectal exam	$n \circ i$	Э	0	0	0	·0·	C
3.26 PSA test	\circ	ĺ,	0	C	D .		_
3.27 Tetanus shot	0	0	0	\circ	0		0
3.28 Vision test	0	-	\circ	0)	Ō	<u> </u>

Health Habits and Life Experiences

exercise (20 minutes or more of nonstop exercise such as jogging, swimming, rapid walking, stair stepping, etc.)? Never Once or less Twice Three or more times I have a physical disability that prevents me from exercising	did you drink alcoholic beverages? Every day 4-6 days per week 2-3 days per week 1 day per week 2-3 days per month 1 day per month Less than 1 day per month Never
4.1 In general, do you consider your nutrition: Excellent Very Good Good Fair Poor	4.3 In the past year, have you: (Mark all that apply) C Felt that you should cut down on your drinking Been annoyed with people criticizing your drinking Felt bad or guilty about your drinking Had a drink first thing in the morning for nerves or a hangover

Please continue on the next page...

© 2000 PhDx Systems, Inc All Rights Reserved



© None from this list





4.4 Have you smoked at least 100 cigarettes in your entire life?	4.9 In the past 24 months, have you had more than one sexual partner?
² Yes	○ Yes
O No (If No; go to question 4.8)	○ No
4.5 Do you smoke cigarettes now?	
C 1/	General Information
○ Yes ○ No	5.0 What is the highest level of education you completed
4.6 About how many cigarettes did or do you smoke, on average, per day (1 pack = 20 cigarettes)?	○ Junior high or middle school
□ Less than 1 pack	○ High school
⇒ Less than 1 pack ⇒ 1 pack	○ Trade or vocational school
○ 2 packs	○ Junior college
© 3 or more packs	○ College
3 or more packs	○ Graduate or professional school
4.7 How many years have you or did you smoke cigarettes?	5.1 Are you currently employed? • Yes
	O No
Years	○ Retired
-	O Retired
4.8 Have you experienced any of the following in the past 12 months? (Mark all that apply)	5.2 Do you consider yourself:
~ D'	 American Indian or Native American
© Divorce	○ Asian or Pacific Islander
© Separation	 Black or African American, Non-Hispanic
© Unemployment	○ Hispanic
© Marriage	○ White, Non-Hispanic
O Death of a spouse	○ Other
Change in job	
© Death of a friend or family member	Thank you for completing the questionnaire.
Major personal injury or illnessChange in health of a family member	Please put it in the self-addressed envelope
Became a parent	and return it.
Job related stress	
Living aloneNone from this list	
2 None Ironi (ins fist	

	Name (Last First, Middle Initial)					
	For Office Use Only					
	Date of Birth					
correct circle or writing in the information. If you are unsultion on the control of the control	onnaire. Using a pencil, answer every question by filling in the re about how to answer a question, please give the best answer the incorrect mark and fill in the correct circle. Mark only one ease do not mark outside of the circle or make stray marks. This: 357 For optimum accuracy, please avoid contact with the outline of boxes.					
Rrief Med	lical History					
1.0 In general, do you think your health is:	1.3 If you were diagnosed with skin cancer, what					
© Excellent	type was it? (Mark all that apply)					
○ Very Good						
ි Good	○ Basal cell carcinoma					
○ Fair	○ Melanoma					
○ Poor	○ Squamous cell carcinoma					
1.1 Have you ever had any of the following?	○ Don't know					
(Mark all that apply)	1.4 Have you ever been told that you have diabetes?					
○ Asthma						
© Breast cysts or tumors, other than cancer	○ Yes ○ No (If 'No', go to question 1.7)					
© Cerebrovascular disease (stroke)	1.5 Do you take insulin?					
○ Congestive heart failure	1.5 Do you take insular					
© Dysplastic nevi (funny looking mole)	○ Yes ○ No					
○ Heart disease	1.6 Do you monitor your blood sugar at home?					
○ Hepatitis B	1.0 Do you moment your blood sugar at nome.					
○ High cholesterol	○ Yes ○ No					
•						
Hypertension (high blood pressure)	1.7 Have you ever had any of the following					
C Kidney failure	procedures? (Mark all that apply)					
Obstructive lung disease						
(emphysema, chronic bronchitis)	© Breast biopsy					
© Osteoporosis (brittle bones)	○ Cardiac catheterization					
7 Tuberculosis	○ Cardiac surgery					
○ None from this list	○ Hysterectomy					
1.2 Have you ever had any of the following	O Pacemaker or defibrillator insertion					
cancers? (Mark all that apply)	 Removal or freezing of an actinic keratosis (rough, scaly patch on skin) 					
○ Breast cancer ○ Skin cancer	Removal of dysplastic nevi (or funny looking mole					
Colon cancer Other cancer	of the skin					
© Lung cancer © Never had cancer	○ I haven't had any of these procedures					
- Long cancer a five ind cancer						

Please continue on the next page...



1.8 Do you use any assistive devices? (Mark all that apply)	1.13 How tall are you?				
© Eye glasses or contact lenses	feet inches				
← Hearing aid(s)					
○ Oxygen	1.14 In the last 6 months, have you gained or lost				
© Walker	10 or more pounds without o	neting?			
○ Wheelchair	© Yes © No				
○ Other	1.15 How old were you when you had your first				
○ I use no assistive devices	period?				
1.9 Do you currently take (prescription,	○ 10 years or younger	0 13			
over-the-counter, or sample) medication	€ 11	○ 14			
for any of the following? (Mark all that apply)	○ 12	ା 15 or older			
○ Asthma	1.16 Have you ever been pregna	ant?			
○ Birth control	C Yes				
○ Cancer	O No (If No', go to question	m 1 19)			
© Cerebrovascular disease (stroke)					
○ Depression	1.17 How old were you when yo	ou had your first child?			
○ Diabetes	C Less than 15 years old	O 30 - 34			
○ Heart disease	○ 15 - 17	35 - 39			
○ High blood pressure	○ 18 - 24	0 40 - 44			
○ High cholesterol	○ 25 - 29	○ 45 or older			
 Menopause or menopausal symptoms 	1.18 Do you still have menstrua	l periods?			
○ Osteoporosis	O Yes (If Yes', go to question	on 2.0)			
○ None from this list	○ No	· · · · · · ·			
1.10 Do you regularly take any of the following? (Mark all that apply)	1.19 Why did your menstrual p	eriod stop?			
○ Aspirin	O Due to surgery or medical	treatment			
© Calcium	○ Due to illness				
© Melatonin	○ Due to pregnancy				
© Selenium	O Due to weight loss				
Other herbal or health supplements	○ Naturally				
I take no herbal or health supplements	© Due to some other reason				
1.11 Do you currently take female hormone replacement therapy (such as Premarin)?	1.20 How old were you when yo periods stopped?	our menstrual			
© Yes © No	○ Younger than 30	○ 45 - 49			
	○ 30 - 34	50 - 54			
1.12 How much do you weigh?	□ 35 - 39	© Older than 54			
pounds	€ 40 - 44				
Please continue	on the next page	37195			

€ 2000 PhDx Systems. Inc All Rights Reserved 100 - 105999

Adult Female Health Overview





Some people have a higher risk of certain diseases. We can help you understand your risk if you tell us about your family.

Family History										
	Father	r's Fa	mily	Moth	er's F	amily	Y	our I	amily	y
If your blood relative(s) had or have the following health conditions, please fill in the circle under that relative. (Mark all that apply)	Grandfather	Grandmother	Father	Grandfather	Grandmother	Mother	Sister(s)	Brother(s)	Daughter(s)	Son(s)
2.0 Heart disease, heart attack or angina? 2.1 Diabetes?	0	0	0 0	0	0	00	0 0	00	0	0
2.2 High blood pressure or stroke?2.3 Colon or rectal cancer?2.4 Melanoma skin cancer?	0 0	0000	0 0	0 0 0	0 0 0 0	0 0 0 0	0 0 0	0 0	0000	0 0
2.5 Breast cancer?2.6 Ovarian cancer?2.7 Other cancer?2.8 Osteoporosis?	C 0	0 0 0	0	0 0	0 0 0 0	0 0 0	0 0 0	0	0000	0
Health Risk and Preventive										
 3.0 How many freckles do you have on your body? None Few (less than 25) Moderate (25 - 50) A lot (more than 50) 	tl	e fir Alv Usu	st tin vays s ially l		one h y bur ith pa				er su	n for
3.1 How many moles (raised spots on your skin that are tan, brown or skin-colored that do not come and go with sun exposure) do you have on your body?	e Rarely or never burn									
 ○ None ○ Few (less than 25) ○ Moderate (25 - 50) ○ A lot (more than 50) 		I ha I ha Nor	ve far ve blue ne of t	r skin ue or g these a	reen pply	eyes	often	do y	ou pi	rotect
3.2 How many times have you had a severe sunburn with blistering and pain?	St	ınblo	ck, o			by usin ig prot	_			?
○ Never○ 1-2 times○ 3 or more times	:	: Alw : Ofte : Son : Nev	en netim	es						

Please continue on the next page...

37193

3.6 Have you seen your primary care phys the past 12 months?	sician in				ie Health Edi roup offers?	ıcation
○ Yes ○ No		○ No				
			and I have:	attended (one or more	
In the past 12 months, has your doctor		•			lasses but hav	۵
recommended that you	N				iasses out hav	C
Yes	No	not a	ttended any	<i>(</i>		
3.7 Practice breast self exam?	0	3.16 Whei	ı you need	to make	health decision	ons, where
3.8 Have a mammogram?	0	do you	get your ir	formatic	n? (Mark all	that apply)
3.9 Check your stool for blood?	0	•	-			
3.10 Wear sunscreen or specific		O Docto	ors	○ Mag	azines or new	spapers
clothing while outside in the sun?	0	○ Famil	ly	\odot SCC	IPA OnCall A	Advice line
3.11 Stop or reduce smoking?	O	○ Frien	ds	○ Tele	vision or radio)
3.12 Modify or change your diet?	0	○ Interr	net	○ Othe	er.	
3.13 Increase your exercise?	5	o mich		o Oth		
3.14 Use seatbelts?	0					
When did you last have the following:		1.5				
•	Less than	1-2	3-5	6-9	10	l don't
N	12 months	-	years	years	10 or more	don't
Never	9	ago	ago	ago	years ago	know
3.17 Blood pressure measured	0	0	0	~ ~	0	0
3.18 Breast exam	O a	0	Ć	0	0	0
3.19 Cholesterol measured	0	. 0	0	0	0	0
3.20 Dental checkup	0	. 0	0	0	0	0
3.21 Diabetes test		0	0	0	0	0
3.22 Electrocardiogram (ECG)		0	0	0 ,:	0	0
3.23 Fecal occult or stool blood test	0	0	0	0	0	0
3.24 Flex sigmoidoscopy (colon exam)	0.	0	0	0		0
3.25 Flu shot	0	\circ	9		0	
3.26 Mammogram	0, ,	0	0	0 .		0
3.27 Pap test	0	0	0		0	
3.28 Pneumovax or pneumonia vaccine	0	0	0	Ô	0	0
3.29 Tetanus shot	<u> </u>	0	<u> </u>		0	0
3.30 Vision test	0	0	Ö	0	0	0
Health I	labits and	Life Exp	perience:	<u> </u>		
4.0 How many times a week do you do aer	robic	4 1 In	ganaral de	VOII COD	sider your nu	trition
exercise (20 minutes or more of nonstop				you con	staci jour na	arraton.
such as jogging, swimming, rapid walk	=	9	Excellent			
stepping, etc.)?	Jug, stair		Very Good			
○ Never ○ Three or more	times	1	Good			
○ Once or less ○ I have a physic	al disability th	hat	Fair			
O Twice prevents me from	=	. C :	Poor			
P	lease contini	ue on the r	iext page	••	;	37195
© 2000 PhDx Systems, Inc		4.00		E000		

000 PhDx Systems, Inc All Rights Reserved

100 105999

	<u> </u>
4.2 During the past year, how often, on average, did you drink alcoholic beverages?	4.8 Have you experienced any of the following in the past 12 months? (Mark all that apply)
© Every day	2 Divorce
© 4-6 days per week	Separation
© 2-3 days per week	© Unemployment
	☐ Marriage
C 1 day per week	© Death of a spouse
© 2-3 days per month	Change in job
○ 1 day per month	Death of a friend or family member
C Less than 1 day per month	Major personal injury or illness
○ Never	Change in health of a family member
4.3 In the past year, have you: (Mark all that apply)	Became a parent
© Felt that you should cut down on your	C Job related stress
drinking	C Living alone
© Been annoyed with people criticizing your	○ None from this list
drinking	4.9 In the past 24 months, have you had more than one
Felt bad or guilty about your drinking	sexual partner?
 Had a drink first thing in the morning for nerves 	୍ର Yes ୍ର No
or a hangover	General Information
O None from this list	[L
	5.0 What is the highest level of education you complete
4.4 Have you smoked at least 100 cigarettes in your	© Grade school © Junior high or middle school
entire life?	C High school
○ Yes ○ No (If No', go to question 4.8)	○ Trade or vocational school
• •	○ Junior college
4.5 Do you smoke cigarettes now?	© College
○ Yes ○ No	○ Graduate or professional school
	5.1 Are you currently employed?
4.6 About how many cigarettes did or do you	☐ Yes ☐ No ☐ Retired
smoke, on average, per day (1 pack = 20 cigarettes)?	5.2 Do you consider yourself:
(1 puer 20 eightenes).	C American Indian or Native American
○ less than 1 pack	O Asian or Pacific Islander
○ 1 pack	C Black or African American, Non-Hispanic
○ 2 packs	C Hispanic
○ 3 or more packs	C White, Non-Hispanic C Other
4.7 How many years have you or did you smoke	2 Other
cigarettes?	Thank you for completing the questionnaire.
	Please put it in the self-addressed envelope
Years	and return it.
	37195

105999

Adult Female Health Overview

100

© 2000 PhDx Systems, Inc All Rights Reserved