	For Officia Use Only
	Date of Birth
correct circle or writing in the information. If you are u	
Brief M	edical History
1.0 In general, do you think your health is:  © Excellent Very Good Good Fair	1.3 If you were diagnosed with skin cancer, what type was it? (Mark all that apply)  Description Basal cell carcinoma Description Melanoma
○ Poor  1.1 Have you ever had any of the following?  (Mark all that apply)	<ul><li>○ Squamous cell carcinoma</li><li>○ Don't know</li><li>1.4 Have you ever been told that you have diabetes?</li></ul>
<ul> <li>○ Asthma</li> <li>○ Cerebrovascular disease (stroke)</li> <li>○ Congestive heart failure</li> <li>○ Dysplastic nevi (funny looking mole)</li> </ul>	Yes (If 'No', go to question 1.7)  1.5 Do you take insulin?
<ul> <li>○ Heart disease</li> <li>○ Hepatitis B</li> <li>○ High cholesterol</li> <li>○ Hypertension (high blood pressure)</li> </ul>	○ Yes ○ No  1.6 Do you monitor your blood sugar at home?
C Kidney failure C Obstructive lung disease (emphysema, chronic bronchitis)	○ Yes ○ No  1.7 Have you ever had any of the following procedures?  (Mark all that apply)
Osteoporosis (brittle bones) Prostate disease Tuberculosis None from this list	<ul> <li>Cardiac catheterization</li> <li>Cardiac surgery</li> <li>Pacemaker or defibrillator insertion</li> <li>Prostate biopsy or surgery</li> </ul>
1.2 Have you ever had any of the following cancers? (Mark all that apply)  Colon cancer  Lung cancer  Prostate cancer  Plance applications of the following cancer  Skin cancer  Other cancer  Never had cancer	Removal or freezing of an actinic keratosis (rough, scaly patch on skin) Removal of dysplastic nevi (or funny looking mole) of the skin 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 ○ Saw palmetto							
○ Oxygen								
○ Walker	○ Selenium							
○ Wheelchair	Other herbal or health supplements							
○ Other	take no herbal or health supplements							
use no assistive devices								
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 got and 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	as as a serie formation with a series							
○ High cholesterol	es es							
○ Osteoporosis	No							
O Prostate disease								
None from this list								
Some people have a high We can help you understand your i	er risk of certain diseases.							
Family History								

Family History										
	Fathe	r's Fa	mily	Moth	er's F	amily	Y	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	0	0	0	0	0	0	0	0	0
2.1 Diabetes ?	-	$\circ$	$\circ$	j o	0	0	0	C,	Ĵ	0
2.2 High blood pressure or stroke?	0	$\circ$			0	0 }	$\circ$	$\circ$	C	0
2.3 Colon or rectal cancer?	0	0		0	0	0	$\circ$	0	$\circ$	$\circ$
2.4 Melanoma skin cancer?	0	0	0	, 0	$\circ$	0 :	0	0	$\bigcirc$	0
2.5 Prostate cancer?	÷.		0	: 0				C:		O
2.6 Other cancer?	0	0	0				0	C	_	0

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Adult Male Health Overview

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3.0 How many freckles do you have on your body?  None	3.5 When you are outside, how often do you protect yourself from the sun by using sunscreen,
© Few (less than 25)	sunblock, or by wearing protective clothing?
Moderate (25 - 50)	O Always
A lot (more than 50)	O Always  Often
,	
3.1 How many moles (raised spots on your skin that are tan, brown or skin-colored that do not come	Sometimes
and go with sun exposure) do you have on your	○ Never
body?	3.6 Have you seen your primary care physician in
○ None	the past 12 months?
ew (less than 25)	γes O No
Moderate (25 -50)	In the past 12 months, has your doctor recommended
O A lot (more than 50)	that you:
C A for (more than 50)	Yes No 3.7 Have a prostate-specific antigen
3.2 How many times have you had a severe sunburn	blood test (PSA)?
with blistering and pain?	3.8 Check your stool for blood?
○ Never	3.9 Wear sunscreen or specific
○ 1-2 times	clothing while outside in the sun?
or more times	3.10 Stop or reduce smoking?
	3.11 Modify or change your diet? O O 3.12 Increase your exercise?
3.3 If your skin was exposed to the summer sun for	
the first time for one hour, would you:	3.13 Use seatbelts?
○ Always severely burn	3.14 Have you heard about the Health Education
○ Usually burn with pain	classes that your medical group offers?
○ Moderately burn	○ No
Inimally burn	○ Yes, and I have attended one or more
Rarely or never burn	○ Yes, I have heard of the classes but have
3.4 Describe your hair, eyes, or skin.	not attended any
(Mark all that apply)	3.15 When you need to make health decisions, where
•••	do you get your information?
○ I have red or blonde hair	(Mark all that apply)
ି I have fair skin	○ Doctors
○ I have blue or green eyes	○ Family
None of these apply to me	○ Friends
	○ Internet
	Magazines or newspapers
	SCCIPA OnCall Advice line
	© Television or radio
	O Other
Diago continuo	n the next nage
Flease Continue C	m the next page 36644
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Adult Male Health Overview

## When did you last have the following:

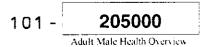
		Less than	1-2	3-5	6-9		I
		12 months	years	years	years	10 or more	don't
	Never	ago	ago	ago	ago	years ago	know
3.16 Blood pressure measured	0	Ĉ	Ĉ	C	()		5
3.17 Cholesterol measured	$\circ$	Ĉ	$\circ$	$\circ$	$\circ$	0	0
3.18 Dental checkup	$\circ$	Ĵ	$\bigcirc$	0	Ç	Ĉ	C ·
3.19 Diabetes test	0	Э	0	$\circ$	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
<b>3.22</b> 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
<b>3.26</b> PSA test	$\circ$	ĺ,	0	C	D .		_
3.27 Tetanus shot	0	0	0	$\circ$	0		0
3.28 Vision test	0	<del>-</del>	0	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...

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© 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?
<sup>2</sup> 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
○ 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
ę	O No
Years	© Retired
<del></del>	C 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:
- P:	American Indian or Native American
© Divorce	○ Asian or Pacific Islander
© Separation	O 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 illness	Please put it in the self-addressed envelope
© Change in health of a family member	and return it.
Became a parent     Tab related attacks	
Job related stress	
C Nove Constable Nove	
None from this list	

	Name (Last. First, Middle Initial)					
	Far Office Use Only					
	Date of Birth					
correct circle or writing in the information. If you are unsur you can. If you need to change an answer, completely erase	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 ase 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	ical 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	20 20 302 122 122					
O 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 monitor your blood sugar at nome.					
○ High cholesterol	○ Yes ○ No					
Hypertension (high blood pressure)						
© Kidney failure	1.7 Have you ever had any of the following					
Obstructive lung disease	procedures? (Mark all that apply)					
(emphysema, chronic bronchitis)	○ Breast biopsy					
• •	Cardiac catheterization					
© Osteoporosis (brittle bones) © Tuberculosis						
* * * *	Cardiac surgery					
○ None from this list	○ Hysterectomy ○ Pacemaker or defibrillator insertion					
1.2 Have you ever had any of the following	Removal or freezing of an actinic keratosis					
cancers? (Mark all that apply)	(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					
C Lang cuncer a frever had cuncer						

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	• •			
© 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	<b>0 13</b>			
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	<b>35 - 39</b>			
○ High blood pressure	○ 18 - 24	<b>0</b> 40 - 44			
○ High cholesterol	O 25 - 29	○ 45 or older			
<ul> <li>Menopause or menopausal symptoms</li> </ul>	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	C 40 - 44				
Please continue	on the next page	37195			

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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 0	0 0	0	0 0	0	0 0
<ul><li>2.2 High blood pressure or stroke?</li><li>2.3 Colon or rectal cancer?</li><li>2.4 Melanoma skin cancer?</li></ul>	0 0 0	0 0 0	0 0	0 0 0	0 0 0	0 0 0	0 0	0 0	0 0 0	0 0
<ul><li>2.5 Breast cancer?</li><li>2.6 Ovarian cancer?</li><li>2.7 Other cancer?</li><li>3.8 Octoopersis?</li></ul>	0	0 0 0	0	0	0 0 0 0	0 0 0 0	0 0 0	0 0	0 0 0 0	0
	2.8 Osteoporosis?  Health Risk and Preventive									
<ul> <li>3.0 How many freckles do you have on your body?</li> <li>None</li> <li>Few (less than 25)</li> <li>Moderate (25 - 50)</li> <li>A lot (more than 50)</li> </ul>	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?	Rarely or never burn									
<ul> <li>○ None</li> <li>○ Few (less than 25)</li> <li>○ Moderate (25 - 50)</li> <li>○ A lot (more than 50)</li> </ul>		I ha I ha Nor	ve far ve blue ne of t	ir skin ue or g these a	reen pply	eyes	often	do v	ou pi	rotect
3.2 How many times have you had a severe sunburn with blistering and pain?	yo St	ourse	elf fro ck, o	m the	sun	by using prot	g sun	scre	en,	
<ul><li>○ Never</li><li>○ 1-2 times</li><li>○ 3 or more times</li></ul>		Ofte	en netim	es						

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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	NI a				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)		
<b>3.9</b> Check your stool for blood?	0	•	-					
3.10 Wear sunscreen or specific		O Docto	ors	○ Mag	azines or new	newspapers		
clothing while outside in the sun?	0	○ Famil	ly	$\odot$ SCC	IPA OnCall A	Advice line		
3.11 Stop or reduce smoking?	<b>O</b>	○ Frien	ds	○ Tele	vision or radio	)		
3.12 Modify or change your diet?	0	○ Interr	net	○ Othe	er.			
3.13 Increase your exercise?	<b>5</b>	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		
<b>N</b>	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	<b>=</b>	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		
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	<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?
<ul> <li>Had a drink first thing in the morning for nerves</li> </ul>	○ Yes ○ 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 pack 20 eigarettes).	C American Indian or Native American
○ less than 1 pack	○ Asian or Pacific Islander
○ 1 pack	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	Cother
cigarettes?	Thank you for completing the questionnaire.
	Please put it in the self-addressed envelope
Years	and return it.
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Adult Female Health Overview

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