Name (Last, First, Middle Initial)

For Office Use Only

Date of Birth

ADULT MALE HEALTH OVERVIEW

Directions: *Please take a few minutes to fill out this questionnaire. Using a pencil, answer every question by filling in the correct circle or writing in the information. If you are unsure about how to answer a question, please give the best answer you can. If you need to change an answer, completely erase the incorrect mark and fill in the correct circle.* **Mark only one answer for each question, unless otherwise instructed. Please do not mark outside of the circle or make stray marks.**

Today's Date: ___ / ___ / ___

Shade circles like this: ● **Not like this:** ⊗ ✓

357 357

For optimum accuracy, please avoid contact with the outline of boxes.

Brief Medical History

1.0 In general, do you think your health is:

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

1.1 Have you ever had any of the following? *(Mark all that apply)*

- ○ Asthma
- ○ Cerebrovascular disease (stroke)
- ○ Congestive heart failure
- ○ Dysplastic nevi (funny looking mole)
- ○ Heart disease
- ○ Hepatitis B
- ○ High cholesterol
- ○ Hypertension (high blood pressure)
- ○ Kidney failure
- ○ Obstructive lung disease (emphysema, chronic bronchitis)
- ○ Osteoporosis (brittle bones)
- ○ Prostate disease
- ○ Tuberculosis
- ○ None from this list

1.2 Have you ever had any of the following cancers? *(Mark all that apply)*

- ○ Colon cancer
- ○ Lung cancer
- ○ Prostate cancer
- ○ Skin cancer
- ○ Other cancer
- ○ Never had cancer

1.3 If you were diagnosed with skin cancer, what type was it? *(Mark all that apply)*

- ○ Basal cell carcinoma
- ○ Melanoma
- ○ Squamous cell carcinoma
- ○ Don't know

1.4 Have you ever been told that you have diabetes?

○ Yes ○ No *(If 'No', go to question 1.7)*

1.5 Do you take insulin?

○ Yes ○ No

1.6 Do you monitor your blood sugar at home?

○ Yes ○ No

1.7 Have you ever had any of the following procedures? *(Mark all that apply)*

- ○ Cardiac catheterization
- ○ Cardiac surgery
- ○ Pacemaker or defibrillator insertion
- ○ Prostate biopsy or surgery
- ○ Removal or freezing of an actinic keratosis (rough, scaly patch on skin)
- ○ Removal of dysplastic nevi (or funny looking mole) of the skin
- ○ I haven't had any of these procedures

Please continue on the next page...

1.8 Do you use any assistive devices? *(Mark all that apply)*

- ○ Eye glasses or contact lenses
- ○ Hearing aid(s)
- ○ Oxygen
- ○ Walker
- ○ Wheelchair
- ○ Other
- ○ I use no assistive devices

1.9 Do you currently take (prescription, over-the-counter, or sample) medication for any of the following? *(Mark all that apply)*

- ○ Asthma
- ○ Cancer
- ○ Cerebrovascular disease (stroke)
- ○ Depression
- ○ Diabetes
- ○ Heart disease
- ○ High blood pressure
- ○ High cholesterol
- ○ Osteoporosis
- ○ Prostate disease
- ○ None from this list

1.10 Do you regularly take any of the following: *(Mark all that apply)*

- ○ Aspirin
- ○ Melatonin
- ○ Saw palmetto
- ○ Selenium
- ○ Other herbal or health supplements
- ○ I take no herbal or health supplements

1.11 How much do you weigh?

☐☐☐ pounds

1.12 How tall are you?

☐ feet ☐☐ inches

1.13 In the last 6 months, have you gained or lost 10 or more pounds without dieting?

- ○ Yes
- ○ No

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

If your blood relative(s) had or have the following health conditions, please fill in the circle under that relative. *(Mark all that apply)*	Father's Family			Mother's Family			Your Family			
	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 ?	○	○	○	○	○	○	○	○	○	○
2.2 High blood pressure or stroke?	○	○	○	○	○	○	○	○	○	○
2.3 Colon or rectal cancer?	○	○	○	○	○	○	○	○	○	○
2.4 Melanoma skin cancer?	○	○	○	○	○	○	○	○	○	○
2.5 Prostate cancer?	○		○	○				○		○
2.6 Other cancer?	○	○	○	○	○	○	○	○	○	○

Please continue on the next page...

3.0 How many freckles do you have on your body?

- ○ None
- ○ Few (less than 25)
- ○ Moderate (25 - 50)
- ○ A lot (more than 50)

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?

- ○ None
- ○ Few (less than 25)
- ○ Moderate (25 -50)
- ○ A lot (more than 50)

3.2 How many times have you had a severe sunburn with blistering and pain?

- ○ Never
- ○ 1-2 times
- ○ 3 or more times

3.3 If your skin was exposed to the summer sun for the first time for one hour, would you:

- ○ Always severely burn
- ○ Usually burn with pain
- ○ Moderately burn
- ○ Minimally burn
- ○ Rarely or never burn

3.4 Describe your hair, eyes, or skin.
(Mark all that apply)

- ○ I have red or blonde hair
- ○ I have fair skin
- ○ I have blue or green eyes
- ○ None of these apply to me

3.5 When you are outside, how often do you protect yourself from the sun by using sunscreen, sunblock, or by wearing protective clothing?

- ○ Always
- ○ Often
- ○ Sometimes
- ○ Never

3.6 Have you seen your primary care physician in the past 12 months?

○ Yes ○ No

In the past 12 months, has your doctor recommended that you:

	Yes	No
3.7 Have a prostate-specific antigen blood test (PSA)?	○	○
3.8 Check your stool for blood?	○	○
3.9 Wear sunscreen or specific clothing while outside in the sun?	○	○
3.10 Stop or reduce smoking?	○	○
3.11 Modify or change your diet?	○	○
3.12 Increase your exercise?	○	○
3.13 Use seatbelts?	○	○

3.14 Have you heard about the Health Education classes that your medical group offers?

- ○ No
- ○ Yes, and I have attended one or more
- ○ Yes, I have heard of the classes but have not attended any

3.15 When you need to make health decisions, where do you get your information?
(Mark all that apply)

- ○ Doctors
- ○ Family
- ○ Friends
- ○ Internet
- ○ Magazines or newspapers
- ○ SCCIPA OnCall Advice line
- ○ Television or radio
- ○ Other

Please continue on the next page...

When did you last have the following:

	Never	Less than 12 months ago	1-2 years ago	3-5 years ago	6-9 years ago	10 or more years ago	I don't know
3.16 Blood pressure measured	○	○	○	○	○	○	○
3.17 Cholesterol measured	○	○	○	○	○	○	○
3.18 Dental checkup	○	○	○	○	○	○	○
3.19 Diabetes test	○	○	○	○	○	○	○
3.20 Electrocardiogram (ECG)	○	○	○	○	○	○	○
3.21 Fecal occult or stool blood test	○	○	○	○	○	○	○
3.22 Flex sigmoidoscopy (colon exam)	○	○	○	○	○	○	○
3.23 Flu shot	○	○	○	○	○	○	○
3.24 Pneumovax or pneumonia vaccine	○	○	○	○	○	○	○
3.25 Prostate exam or digital rectal exam	○	○	○	○	○	○	○
3.26 PSA test	○	○	○	○	○	○	○
3.27 Tetanus shot	○	○	○	○	○	○	○
3.28 Vision test	○	○	○	○	○	○	○

Health Habits and Life Experiences

4.0 How many times a week do you do aerobic 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

4.1 In general, do you consider your nutrition:

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

4.2 During the past year, how often, on average, 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

4.3 In the past year, have you: *(Mark all that apply)*

- ○ 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
- ○ None from this list

Please continue on the next page...

4.4 Have you smoked at least 100 cigarettes in your entire life?

- ○ Yes
- ○ No *(If 'No', go to question 4.8)*

4.5 Do you smoke cigarettes now?

- ○ Yes
- ○ No

4.6 About how many cigarettes did or do you smoke, on average, per day (1 pack = 20 cigarettes)?

- ○ Less than 1 pack
- ○ 1 pack
- ○ 2 packs
- ○ 3 or more packs

4.7 How many years have you or did you smoke cigarettes?

[ ] **Years**

4.8 Have you experienced any of the following in the past 12 months? *(Mark all that apply)*

- ○ Divorce
- ○ Separation
- ○ Unemployment
- ○ Marriage
- ○ Death of a spouse
- ○ Change in job
- ○ Death of a friend or family member
- ○ Major personal injury or illness
- ○ Change in health of a family member
- ○ Became a parent
- ○ Job related stress
- ○ Living alone
- ○ None from this list

4.9 In the past 24 months, have you had more than one sexual partner?

- ○ Yes
- ○ No

General Information

5.0 What is the highest level of education you completed?

- ○ Grade school
- ○ Junior high or middle school
- ○ High school
- ○ Trade or vocational school
- ○ Junior college
- ○ College
- ○ Graduate or professional school

5.1 Are you currently employed?

- ○ Yes
- ○ No
- ○ Retired

5.2 Do you consider yourself:

- ○ American Indian or Native American
- ○ Asian or Pacific Islander
- ○ Black or African American, Non-Hispanic
- ○ Hispanic
- ○ White, Non-Hispanic
- ○ Other

Thank you for completing the questionnaire. Please put it in the self-addressed envelope and return it.

Name (Last, First, Middle Initial)

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Date of Birth

ADULT FEMALE HEALTH OVERVIEW

Directions: *Please take a few minutes to fill out this questionnaire. Using a pencil, answer every question by filling in the correct circle or writing in the information. If you are unsure about how to answer a question, please give the best answer you can. If you need to change an answer, completely erase the incorrect mark and fill in the correct circle.* **Mark only one answer for each question, unless otherwise instructed. Please do not mark outside of the circle or make stray marks.**

Today's Date: ___/___/_____

Shade circles like this: ● **Not like this:** ⊗ ✓ 357 357

For optimum accuracy, please avoid contact with the outline of boxes.

Brief Medical History

1.0 In general, do you think your health is:

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

1.1 Have you ever had any of the following? *(Mark all that apply)*

- ○ Asthma
- ○ Breast cysts or tumors, other than cancer
- ○ Cerebrovascular disease (stroke)
- ○ Congestive heart failure
- ○ Dysplastic nevi (funny looking mole)
- ○ Heart disease
- ○ Hepatitis B
- ○ High cholesterol
- ○ Hypertension (high blood pressure)
- ○ Kidney failure
- ○ Obstructive lung disease (emphysema, chronic bronchitis)
- ○ Osteoporosis (brittle bones)
- ○ Tuberculosis
- ○ None from this list

1.2 Have you ever had any of the following cancers? *(Mark all that apply)*

- ○ Breast cancer
- ○ Colon cancer
- ○ Lung cancer
- ○ Skin cancer
- ○ Other cancer
- ○ Never had cancer

1.3 If you were diagnosed with skin cancer, what type was it? *(Mark all that apply)*

- ○ Basal cell carcinoma
- ○ Melanoma
- ○ Squamous cell carcinoma
- ○ Don't know

1.4 Have you ever been told that you have diabetes?

○ Yes ○ No *(If 'No', go to question 1.7)*

1.5 Do you take insulin?

○ Yes ○ No

1.6 Do you monitor your blood sugar at home?

○ Yes ○ No

1.7 Have you ever had any of the following procedures? *(Mark all that apply)*

- ○ Breast biopsy
- ○ Cardiac catheterization
- ○ Cardiac surgery
- ○ Hysterectomy
- ○ Pacemaker or defibrillator insertion
- ○ Removal or freezing of an actinic keratosis (rough, scaly patch on skin)
- ○ Removal of dysplastic nevi (or funny looking mole) of the skin
- ○ I haven't had any of these procedures

Please continue on the next page...

1.8 Do you use any assistive devices?
(Mark all that apply)

- ○ Eye glasses or contact lenses
- ○ Hearing aid(s)
- ○ Oxygen
- ○ Walker
- ○ Wheelchair
- ○ Other
- ○ I use no assistive devices

1.9 Do you currently take (prescription, over-the-counter, or sample) medication for any of the following? *(Mark all that apply)*

- ○ Asthma
- ○ Birth control
- ○ Cancer
- ○ Cerebrovascular disease (stroke)
- ○ Depression
- ○ Diabetes
- ○ Heart disease
- ○ High blood pressure
- ○ High cholesterol
- ○ Menopause or menopausal symptoms
- ○ Osteoporosis
- ○ None from this list

1.10 Do you regularly take any of the following?
(Mark all that apply)

- ○ Aspirin
- ○ Calcium
- ○ Melatonin
- ○ Selenium
- ○ Other herbal or health supplements
- ○ I take no herbal or health supplements

1.11 Do you currently take female hormone replacement therapy (such as Premarin)?

○ Yes ○ No

1.12 How much do you weigh?

[ ][ ][ ] pounds

1.13 How tall are you?

[ ] feet [ ][ ] inches

1.14 In the last 6 months, have you gained or lost 10 or more pounds without dieting?

○ Yes ○ No

1.15 How old were you when you had your first period?

- ○ 10 years or younger
- ○ 11
- ○ 12
- ○ 13
- ○ 14
- ○ 15 or older

1.16 Have you ever been pregnant?

- ○ Yes
- ○ No *(If 'No', go to question 1.18)*

1.17 How old were you when you had your first child?

- ○ Less than 15 years old
- ○ 15 - 17
- ○ 18 - 24
- ○ 25 - 29
- ○ 30 - 34
- ○ 35 - 39
- ○ 40 - 44
- ○ 45 or older

1.18 Do you still have menstrual periods?

- ○ Yes *(If 'Yes', go to question 2.0)*
- ○ No

1.19 Why did your menstrual period stop?

- ○ Due to surgery or medical treatment
- ○ Due to illness
- ○ Due to pregnancy
- ○ Due to weight loss
- ○ Naturally
- ○ Due to some other reason

1.20 How old were you when your menstrual periods stopped?

- ○ Younger than 30
- ○ 30 - 34
- ○ 35 - 39
- ○ 40 - 44
- ○ 45 - 49
- ○ 50 - 54
- ○ Older than 54

Please continue on the next page...

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

If your blood relative(s) had or have the following health conditions, please fill in the circle under that relative. *(Mark all that apply)*	Father's Family			Mother's Family			Your Family			
	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?	○	○	○	○	○	○	○	○	○	○
2.2 High blood pressure or stroke?	○	○	○	○	○	○	○	○	○	○
2.3 Colon or rectal cancer?	○	○	○	○	○	○	○	○	○	○
2.4 Melanoma skin cancer?	○	○	○	○	○	○	○	○	○	○
2.5 Breast cancer?		○			○	○	○		○	
2.6 Ovarian cancer?		○			○	○	○		○	
2.7 Other cancer?	○	○	○	○	○	○	○	○	○	○
2.8 Osteoporosis?	○	○	○	○	○	○	○	○	○	○

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)

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?

- ○ None
- ○ Few (less than 25)
- ○ Moderate (25 - 50)
- ○ A lot (more than 50)

3.2 How many times have you had a severe sunburn with blistering and pain?

- ○ Never
- ○ 1-2 times
- ○ 3 or more times

3.3 If your skin was exposed to the summer sun for the first time for one hour, would you:

- ○ Always severely burn
- ○ Usually burn with pain
- ○ Moderately burn
- ○ Minimally burn
- ○ Rarely or never burn

3.4 Describe your hair, eyes, or skin.
(Mark all that apply)

- ○ I have red or blonde hair
- ○ I have fair skin
- ○ I have blue or green eyes
- ○ None of these apply to me

3.5 When you are outside, how often do you protect yourself from the sun by using sunscreen, sunblock, or by wearing protective clothing?

- ○ Always
- ○ Often
- ○ Sometimes
- ○ Never

Please continue on the next page...

3.6 Have you seen your primary care physician in the past 12 months?

○ Yes ○ No

In the past 12 months, has your doctor recommended that you:

	Yes	No
3.7 Practice breast self exam?	○	○
3.8 Have a mammogram?	○	○
3.9 Check your stool for blood?	○	○
3.10 Wear sunscreen or specific clothing while outside in the sun?	○	○
3.11 Stop or reduce smoking?	○	○
3.12 Modify or change your diet?	○	○
3.13 Increase your exercise?	○	○
3.14 Use seatbelts?	○	○

3.15 Have you heard about the Health Education classes that your medical group offers?

○ No
○ Yes, and I have attended one or more
○ Yes, I have heard of the classes but have not attended any

3.16 When you need to make health decisions, where do you get your information? *(Mark all that apply)*

○ Doctors
○ Family
○ Friends
○ Internet
○ Magazines or newspapers
○ SCCIPA OnCall Advice line
○ Television or radio
○ Other

When did you last have the following:

	Never	Less than 12 months ago	1-2 years ago	3-5 years ago	6-9 years ago	10 or more years ago	I don't know
3.17 Blood pressure measured	○	○	○	○	○	○	○
3.18 Breast exam	○	○	○	○	○	○	○
3.19 Cholesterol measured	○	○	○	○	○	○	○
3.20 Dental checkup	○	○	○	○	○	○	○
3.21 Diabetes test	○	○	○	○	○	○	○
3.22 Electrocardiogram (ECG)	○	○	○	○	○	○	○
3.23 Fecal occult or stool blood test	○	○	○	○	○	○	○
3.24 Flex sigmoidoscopy (colon exam)	○	○	○	○	○	○	○
3.25 Flu shot	○	○	○	○	○	○	○
3.26 Mammogram	○	○	○	○	○	○	○
3.27 Pap test	○	○	○	○	○	○	○
3.28 Pneumovax or pneumonia vaccine	○	○	○	○	○	○	○
3.29 Tetanus shot	○	○	○	○	○	○	○
3.30 Vision test	○	○	○	○	○	○	○

Health Habits and Life Experiences

4.0 How many times a week do you do aerobic 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

4.1 In general, do you consider your nutrition:

○ Excellent
○ Very Good
○ Good
○ Fair
○ Poor

Please continue on the next page...

4.2 During the past year, how often, on average, 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

4.3 In the past year, have you: *(Mark all that apply)*

- ○ 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
- ○ None from this list

4.4 Have you smoked at least 100 cigarettes in your entire life?

○ Yes ○ No *(If 'No', go to question 4.8)*

4.5 Do you smoke cigarettes now?

○ Yes ○ No

4.6 About how many cigarettes did or do you smoke, on average, per day (1 pack = 20 cigarettes)?

- ○ less than 1 pack
- ○ 1 pack
- ○ 2 packs
- ○ 3 or more packs

4.7 How many years have you or did you smoke cigarettes?

☐☐ **Years**

4.8 Have you experienced any of the following in the past 12 months? *(Mark all that apply)*

- ○ Divorce
- ○ Separation
- ○ Unemployment
- ○ Marriage
- ○ Death of a spouse
- ○ Change in job
- ○ Death of a friend or family member
- ○ Major personal injury or illness
- ○ Change in health of a family member
- ○ Became a parent
- ○ Job related stress
- ○ Living alone
- ○ None from this list

4.9 In the past 24 months, have you had more than one sexual partner?

○ Yes ○ No

General Information

5.0 What is the highest level of education you completed?

- ○ Grade school
- ○ Junior high or middle school
- ○ High school
- ○ Trade or vocational school
- ○ Junior college
- ○ College
- ○ Graduate or professional school

5.1 Are you currently employed?

○ Yes ○ No ○ Retired

5.2 Do you consider yourself:

- ○ American Indian or Native American
- ○ Asian or Pacific Islander
- ○ Black or African American, Non-Hispanic
- ○ Hispanic
- ○ White, Non-Hispanic
- ○ Other

Thank you for completing the questionnaire. Please put it in the self-addressed envelope and return it.