THE PACIFIC HEART, LUNG, & BLOOD INSTITUTE
INTERNATIONAL HUMAN TISSUE BANK FOR RESEARCH

HEALTH QUESTIONNAIRE

PERSONAL DATA:

Please answer the following questions:

Name: _____ Today's date: _____

Street: _____ Age: _____ Birthdate:_____

City: _____ Birthplace: _____

State:_____ Zip Code: _____

Home Number: (____) _____

Cellular Number: (____) _____

CURRENT PRIMARY CARE PROVIDER:

Please provide information on your current primary care provider (optional, but recommended):

Name: _____ State: _____ Zip Code:_____

Street: _____ Telephone Number: (____) _____

City: _____ Fax Number: (____)_____

DESCRIPTION OF PRESENT HEALTH:

Please briefly describe any present illness, your symptoms, and all tests/treatment you have received:

_____

_____

_____

_____

CHEST SYMPTOMS:

☐ **I have NEVER experienced any of the symptoms below**

Please indicate if you have now or have ever experienced any of the following? (Check all that apply):

- ☐ New/changing cough
- ☐ Phlegm/sputum production
  - ☐ clear ☐ white ☐ green
  - ☐ brown ☐ bloody
- ☐ Hoarseness/change in voice
- ☐ Wheezing
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Pleurisy
- ☐ Shortness of breath with exertion
- ☐ Shortness of breath at rest
- ☐ Chest pain
- ☐ Difficulty swallowing
- ☐ Food "sticking"
- ☐ Pain with swallowing
- ☐ Regurgitation of food
- ☐ Nausea/vomiting
- ☐ Vomiting blood
- ☐ Ulcers/stomach trouble
- ☐ Loss of appetite
- ☐ Weight loss:_____lbs.
- ☐ Weight gain:_____lbs.
- ☐ Fever
- ☐ Night sweats
- ☐ Chest pressure/tightness
- ☐ Heart attack
- ☐ Fast/irregular heart beats
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Ankle swelling
- ☐ Difficulty breathing at night
- ☐ Difficulty breathing lying flat
- ☐ Headaches
- ☐ Weakness/fatigue
- ☐ Pain/aches in joints
- ☐ Other:_____

CURRENT MEDICATIONS:

☐ **Currently, I am NOT taking ANY medications**

Please list **ALL** medications, doses, and frequencies (i.e., twice a day, every 8 hrs, etc.) below:

Name	Dose	How often?	Name	Dose	How often?

☐ **I sometimes take over the counter medications containing Aspirin (Anacin, etc.).**
☐ **I sometimes take over the counter medications containing Ibuprofen (Advil, Motrin, etc.).**

MEDICATION/FOOD ALLERGIES:

☐ **I have NO known food or drug allergies**

Please list **ALL** allergies and reactions to medications and food:

Medication/Food	Reaction:

SUBSTANCE USE:

Please answer the following questions:

Tobacco:

Do you now, or have you ever smoked cigarettes? ☐Yes ☐No

At the most, how many packs of cigarettes did/do you smoke each day? _____packs

At what age did you start smoking? _____years

Are you currently smoking? ☐Yes ☐No If no, at what age did you quit?_____

Do you now, or have you ever smoked cigars, or a pipe? ☐Yes ☐No

Do people close to you smoke? ☐Yes ☐No

How soon after you wake up do you start smoking? ☐Within 30 min. ☐After 30 min

How interested are you in stopping smoking? ☐Not at all ☐A little ☐somewhat ☐very interested

If you decided to quit smoking during the next 2 weeks, how confident are you that you would succeed?

☐Not at all ☐A little ☐somewhat ☐very confident

Alcohol:

Do you now, or did you ever drink alcohol? ☐Yes ☐No

If yes, how much beer do you, or did you drink? _____/day

How much wine do you, or did you drink? _____/day

How much hard liquor do you, or did you drink? _____/day

During the last week, on how many days did you have a drink? _____days

When was the last time you drank an alcoholic beverage? _____

Have you ever felt bad or guilty about your drinking? ☐Yes ☐No

Have you ever had to have a drink in the morning to steady your nerves? ☐Yes ☐No

Have you ever had black-outs or memory loss? ☐Yes ☐No

Have you ever had seizures or the "DT's"? ☐Yes ☐No

Other:

Do you drink coffee? ☐Yes ☐No

If yes, how many cups each day do you drink? _____

Have you ever been exposed to asbestos? ☐Yes ☐No

If yes, when were you exposed? _____

How were you exposed? _____

Have you ever used any drugs such as marijuana, cocaine, amphetamines? ☐Yes ☐No

If yes, which one(s): _____ when was the last time used: _____

Have you ever injected drugs (such as heroin, or cocaine), into your veins? ☐Yes ☐No

If yes, which one(s): _____ when was the last time used: _____

PREVIOUS SURGERY:

☐ **I have NEVER had an operation of any kind**

Please list **ALL** operations you have had including: tonsils, appendix, hemorrhoids, hysterectomy, prostate surgery, etc:

DATE	OPERATION	HOSPITAL	SURGEON

HOSPITALIZATIONS:

☐ **I have NEVER been hospitalized for any reason**

Please list all hospitalizations excluding those for uncomplicated child birth:

DATE	ILLNESS	HOSPITAL	PHYSICIAN

MEDICAL HISTORY

☐ **I have NEVER experienced any of the symptoms below**

Please specify (if not already) if you have now or have ever been told that you have any of the following? (Check all that apply):

☐ Abnormal EKG
☐ Abnormal Treadmill test
☐ Angina/chest discomfort or pressure
☐ Heart attack
☐ Heart condition
☐ Other:_____

☐ High blood pressure
☐ Diabetes
☐ Stroke
☐ Kidney Problem
☐ Phlebitis
☐ Other: _____

RADIATION THERAPY:

☐ **I have NEVER received radiation therapy of any kind**

Please list any prior radiation treatments you have received:

START DATE	STOP DATE	BODY AREA TREATED	HOSPITAL	PHYSICIAN

CHEMOTHERAPY:

☐ **I have NEVER received chemotherapy of any kind**

Please list any chemotherapeutic agents you have received:

START DATE	STOP DATE	AGENTS (IF KNOWN)	HOSPITAL	PHYSICIAN

FAMILY HISTORY:

☐ **I have no knowledge of any of my living or deceased relatives**

Please record the state of health of your close blood relatives, i.e., mother, father, sisters, brothers, aunts, uncles, and grandparents:

RELATIVE	ALIVE? YES/NO	HEALTH PROBLEMS/CAUSE OF DEATH	AGE NOW/AT DEATH
Father			
Mother			
Grandfather			
Grandfather			
Grandmother			
Grandmother			
Sister/Brother			
Sister/Brother			
Sister/Brother			
Sister/Brother			
Other:_____			
Other:_____			

Please indicate if **ANY** of your blood relatives has/had any of the following conditions (check all which apply):

HEALTH PROBLEM	RELATIVES AFFECTED:	HEALTH PROBLEM:	RELATIVES AFFECTED
☐ Alcoholism		☐ Hepatitis	
☐ Anemia/unusual bleeding		☐ High Blood Pressure	
☐ Arthritis		☐ High Cholesterol	
☐ Asthma		☐ Kidney problems	
☐ Cancer		☐ Liver problems	
☐ Diabetes		☐ Obesity	
☐ Glaucoma		☐ Strokes	
☐ Gout		☐ Tuberculosis	
☐ Heart trouble		☐ Other:_____	

SOCIAL HISTORY:

Please complete the following questions as **COMPLETELY** as possible:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment history: ☐ Currently employed Occupation:_____ Employer: _____
☐ Unemployed ☐ Retired (Date): _____ ☐ Disabled (Date): _____
Previous Occupation: _____

What level of education have you attained? ☐ Grade school ☐ High School ☐ College ☐ Professional

Have you traveled outside the U.S? ☐ No ☐ Yes If yes, Where?_____ When?_____

Have you ever served in the military? ☐ No ☐ Yes If yes, Which branch?_____

With whom do you live _____ ☐ I live alone

Do you have difficulty dressing yourself? ☐ No ☐ Yes

Do you have difficulty carrying a 10 lb. bag or shopping? ☐ No ☐ Yes

Have you ever fallen at home? ☐ No ☐ Yes If yes, When? _____

Are you receiving any special help at home? ☐ No ☐ Yes If yes, Who helps you? _____

Do you follow any special diet? ☐ No ☐ Vegetarian ☐ Kosher ☐ Low fat ☐ Other: _____

GYNECOLOGIC/OBSTETRICAL HISTORY (WOMEN ONLY):

Please answer the following questions:

Gynecologic History:

At what age did you begin menstruating? _____years

What is/was the interval between your menstrual periods? _____days/weeks

What is/was the duration of your menstrual periods? _____days

What is/was the date that your last period began? _____

Have you stopped having menstrual periods? ☐No ☐Yes If so, when?_____

Have you ever had irregular, painful, or heavy menstrual periods? ☐No ☐Yes

Have you ever had bleeding between periods or after menopause? ☐No ☐Yes

Do you have problems with vaginal discharge, pain, or itching? ☐No ☐Yes

Do you have "hot flashes"? ☐No ☐Yes

Have you ever had an abnormal Pap smear? ☐No ☐Yes If so, when?_____

When was your most recent Pap smear?_____

When was your most recent Pelvic exam? _____

Have you ever had a Mammogram? ☐No ☐Yes If so, date of last exam? _____

How often do you examine your breasts? ☐Never ☐Monthly ☐Other_____

Would you like instruction in breast self-examination? ☐No ☐Yes

Obstetrical History:

Have you ever been pregnant? ☐No ☐Yes If so, number of times: _____

How many children have you delivered? _____

How many miscarriages have you had? _____

How many abortions have you had?_____

Are you currently using any form of birth control? ☐No ☐Yes If so, what type?_____

Have you ever used birth control pills? ☐No ☐Yes If so, for how long?_____

Have you had a hysterectomy? ☐No ☐Yes If so, when?_____

Have you had your ovaries removed? ☐No ☐Yes If so, when?_____
☐One ovary ☐Both ovaries

Are you now or have you ever been on estrogen(hormone)replacement? ☐No ☐Yes

REVIEW OF SYSTEMS:

Please indicate if you have now or have ever experienced any of the following symptoms (Check all that apply):

SYMPTOM	WHEN		SYMPTOM	WHEN	
Infections			Hemorrhoids	☐ Now	☐ In Past
Mumps	☐ Now	☐ In Past	Jaundice	☐ Now	☐ In Past
German measles	☐ Now	☐ In Past	Hepatitis	☐ Now	☐ In Past
Rheumatic fever	☐ Now	☐ In Past	Cirrhosis	☐ Now	☐ In Past
Rubella	☐ Now	☐ In Past	Liver problems	☐ Now	☐ In Past
Mononucleosis	☐ Now	☐ In Past	Blood transfusions	☐ Now	☐ In Past
Polio	☐ Now	☐ In Past	Gallbladder trouble	☐ Now	☐ In Past
Malaria	☐ Now	☐ In Past	**Urine**		
Typhoid fever	☐ Now	☐ In Past	Blood in urine	☐ Now	☐ In Past
Shingles	☐ Now	☐ In Past	Sugar in urine	☐ Now	☐ In Past
Gonorrhea	☐ Now	☐ In Past	Albumin/protein in urine	☐ Now	☐ In Past
Syphilis	☐ Now	☐ In Past	Cloudy urine	☐ Now	☐ In Past
Skin			Kidney stones	☐ Now	☐ In Past
Rashes	☐ Now	☐ In Past	**Prostate (men only)**		
Tumors/unusual moles	☐ Now	☐ In Past	Slow urine stream	☐ Now	☐ In Past
Psoriasis/eczema (circle one)	☐ Now	☐ In Past	Urination at night: (# of times__)	☐ Now	☐ In Past
Hair loss	☐ Now	☐ In Past	**Circulation/Vascular**		
Eye			Leg pain with walking	☐ Now	☐ In Past
Eye infection/pink eye	☐ Now	☐ In Past	Poor circulation	☐ Now	☐ In Past
Blurred vision	☐ Now	☐ In Past	Varicose veins	☐ Now	☐ In Past
Cataracts	☐ Now	☐ In Past	**Muscles/Joints**		
Glaucoma	☐ Now	☐ In Past	Back/bone pain	☐ Now	☐ In Past
Ears			Arthritis/rheumatism	☐ Now	☐ In Past
Earache/discharge from ear(s)	☐ Now	☐ In Past	Joint pains/deformity/redness	☐ Now	☐ In Past
Ringing in the ears	☐ Now	☐ In Past	Pain with weather changes	☐ Now	☐ In Past
Spinning sensation/vertigo	☐ Now	☐ In Past	Finger changing colors	☐ Now	☐ In Past
Hearing loss	☐ Now	☐ In Past	Drainage from joints	☐ Now	☐ In Past
Nose and Mouth			Locking joints	☐ Now	☐ In Past
Sinus trouble	☐ Now	☐ In Past	Muscle aches/stiffness	☐ Now	☐ In Past
Nosebleeds	☐ Now	☐ In Past	Motion limitation	☐ Now	☐ In Past
Bleeding gums	☐ Now	☐ In Past	**Reproduction**		
Sore tongue	☐ Now	☐ In Past	Pain with intercourse	☐ Now	☐ In Past
Teeth trouble	☐ Now	☐ In Past	Impotence/loss of libido	☐ Now	☐ In Past
Lymph			**Neurological**		
Lumps in groin(s)	☐ Now	☐ In Past	Paralysis	☐ Now	☐ In Past
Neck swelling	☐ Now	☐ In Past	Numbness/tingling of feet/hands	☐ Now	☐ In Past
Lumps in armpits	☐ Now	☐ In Past	Difficulty walking	☐ Now	☐ In Past
Breasts			Coordination problem/clumsiness	☐ Now	☐ In Past
Lumps/pain in breast(s)	☐ Now	☐ In Past	Speech/memory problems	☐ Now	☐ In Past
Nipple discharge	☐ Now	☐ In Past	Loss of bowel/bladder control	☐ Now	☐ In Past
Gastrointestinal			Dizziness/fainting spells	☐ Now	☐ In Past
Ulcers/stomach trouble	☐ Now	☐ In Past	Epilepsy/seizures	☐ Now	☐ In Past
Black/tarry bowel movements	☐ Now	☐ In Past	**Psychological**		
Bright red bowel movements	☐ Now	☐ In Past	Excessive worry/nervousness	☐ Now	☐ In Past
Unusual constipation:	☐ Now	☐ In Past	Depression/nervous disorder	☐ Now	☐ In Past
Unusual diarrhea	☐ Now	☐ In Past	Personality disorder	☐ Now	☐ In Past
Change in stool size	☐ Now	☐ In Past	**Endocrine**		
Change in stool color	☐ Now	☐ In Past	Thyroid problems	☐ Now	☐ In Past
Change in stool frequency	☐ Now	☐ In Past	Head/cold intolerance (circle one)	☐ Now	☐ In Past
Indigestion/"gas"	☐ Now	☐ In Past	Unusual thirst/appetite	☐ Now	☐ In Past
Abdominal pain	☐ Now	☐ In Past	Hand/foot swelling/enlargement	☐ Now	☐ In Past