

English

# Health Questionnaire

Date of Visit: --

## Basic information

Name

Last Name:

First Name:

Gender

Male

Female

Date of Birth (M-D-Y):

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**Past Medical History**

Not applicable to the below diagnosis

Diagnosis	Yes	Medication	Remark
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>	
Angina/Myocardiac Infarction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Percutaneous coronary intervention/Stent <input type="checkbox"/> Operation
CVA (Stroke)	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Decreased renal function <input type="checkbox"/> Dialysis
Liver Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	
Others Diseases	<input type="checkbox"/>		<input type="checkbox"/> Sites: <input type="checkbox"/> Diagnosis:

Cancer	<input type="checkbox"/> Lung	<input type="checkbox"/> Stomach	<input type="checkbox"/> Colon/Sigmoid	<input type="checkbox"/> Liver
	<input type="checkbox"/> Breast	<input type="checkbox"/> Cervix	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Prostate
	<input type="checkbox"/> Other			

Abdominal Surgery	Lesion:		
	<input type="checkbox"/> Stomach/Duodenum	<input type="checkbox"/> Colon/Sigmoid	<input type="checkbox"/> Appendix
	<input type="checkbox"/> Gall bladder	<input type="checkbox"/> Liver	<input type="checkbox"/> Pancreas
	<input type="checkbox"/> Kidney	<input type="checkbox"/> Uterus	<input type="checkbox"/> Ovary/Fallopian tube
	Diagnosis:		

Other Surgery	Lesion:
	Diagnosis:



## Smoking History

Have you smoked at least 5 packs (100 cigarettes) in the life?

No

Smoked in the past, but quit

How long has it been since you quit smoking cigarettes? ( ) year(s)

How long have you smoked? ( ) year(s)

How many cigarettes did you smoke a day? ( ) cigarette(s)

Currently smoking

How long have you been smoking? ( ) year(s)

How many cigarettes do you smoke a day? ( ) cigarette(s)

## Alcohol Drinking Habit

How often do you drink alcohol?

◦ Per month:  less than once  2~4 times

◦ Per week:  twice  3 times  4 times  5 times  6 times  7 times

How much do you usually drink at a time?

(Count each glass of the type of alcohol. Ex. Beer 1 can (355cc) = beer 1.6 glasses)

1~2 glass(es)  3~4 glasses  5~6 glasses

7~9 glasses  more than 10 glasses

**Exercise Related**

<p>Think about all the vigorous activities (activities that take hard physical effort and make you breathe much harder than normal) that you did in the last 7 days. Think only about those physical activities that you did for at least 10 minutes at a time. During the last 7 days, on how many days did you do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling?</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	<p>How much time did you usually spend doing vigorous physical activities on one of those days:  <input type="text"/><input type="text"/><input type="text"/> Minute(s)/day</p>
<p>Think about all the moderate activities (activities that take moderate physical effort and make you breathe somewhat harder than normal) that you did in the last 7 days. Think only about those physical activities that you did for at least 30 minutes at a time. During the last 7 days, on how many days did you do moderate physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis?</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	<p>How much time did you usually spend doing moderate physical activities on one of those days:  <input type="text"/><input type="text"/><input type="text"/> Minute(s)/day</p>
<p>Think about the time you spent walking in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure. During the last 7 days, on how many days did you walk for at least 10 minutes at a time?</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	<p>How much time did you usually spend walking on one of those days:  <input type="text"/><input type="text"/><input type="text"/> Minute(s)/day</p>