U.S. ENVIRONMENTAL PROTECTION AGENCY

Human Studies Facility

Medical History Questionnaire

Today's Date: ____________________________

Name: ____
(Last) (First) (Middle) (Maiden name)

Address: ____

____

Age: ____________ Date of Birth: ____________________________________

U.S. EPA HUMAN STUDIES FACILITY MEDICAL HISTORY QUESTIONAIRE

DEMOGRAPHICS

SEX:

□ Male □ Female

ARE YOU A TWIN, TRIPLET….?

□ Yes □ No

PLACE OF BIRTH:

□ USA
□ OTHER
(Please specify) ________________

RACE

□ Black/African American
□ White
□ Native American
□ Asian/Pacific Islander
□ Asian Indian
□ Hispanic
□ Other

MARITAL STATUS

□ Married
□ Single
□ Divorced
□ Separated
□ Widowed

HIGHEST EDUCATION LEVEL

□ Grade or middle school
□ High school
□ Trade school
□ College
□ Graduate school

Estimated weight in clothes ________________ LBS Estimated height _________________FT & IN

ALLERGIES/SKIN CONDITIONS

An allergy is a condition of an abnormal or excessive response to a substance which is harmless in similar amounts for most people. Hay fever, asthma flare, hives and eczema are types of allergies.

Have you EVER had any of the following? □ Yes □ No

□ Hay fever	□ Eczema	□ Asthma
□ Hives	□ Anaphylaxis	□ Skin trouble other than hives or eczema

Are you CURRENTLY taking, or have you EVER taken "allergy shots"? □ Yes □ No

Are you allergic to bees, wasps, hornets or other stinging insects? □ Yes □ No □ I don't know

Have you EVER had an allergic reaction to any of the following? □ Yes □ No

□ Iodine or X-Ray contrast	□ Latex	□ Aspirin
□ Antibiotics	□ Adhesive tape	□ Novocaine or other local anesthetic
□ Other medication not listed:		

MEDICATIONS

Please mark all medications you are CURRENTLY taking from the following list:

□ Beta blocker	□ Diuretic (to lose water)	□ Cortisone
□ Blood pressure medications	□ Herbal supplements	□ Thyroid
□ Antibiotics	□ Antihistamines	□ Female hormone
□ Antidepressants	□ Sleeping pills	□ Vitamins
□ Birth control pills	□ Narcotic for pain (Codeine, Morphine, etc.)	□ Insulin or other diabetic medication
□ Blood thinners	□ Appetite suppressants	□ Antacids
□ Aspirin, Bufferin, BC's, Anacin, etc.(as many as 4 tablets per day more than 3 times week?	□ Ibuprofen (Motrin) or other Over the Counter pain medications more than 3 times a week?	□ Asthma inhalers or pills □ None

Please list any OTHER MEDICATIONS, herbals or supplements you are CURRENTLY taking:

1.______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

5. ______________________________ 6. ______________________________

7. ______________________________ 8. ______________________________

9. ______________________________ 10. ______________________________

Please mark all medications YOU HAVE EVER TAKEN IN THE PAST from the following list:

□ Beta blocker	□ Diuretic (to lose water)	□ Medicine to lower blood pressure
□ Antibiotics	□ Antihistamines	□ Thyroid medicine
□ Antidepressants	□ Narcotic for pain (Codeine, Morphine, etc.)	□ Insulin or other diabetic medication
□ Blood thinners (anti-coagulant) □ None	□ Asthma inhalers or pills	□ Aspirin, Bufferin, BC's, Anacin, etc. (as many as 4 tablets per day more than 3 times week?

Please list any OTHER MEDICATIONS, herbals or supplements you HAVE TAKEN IN THE PAST:

1.______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

5. ______________________________ 6. ______________________________

7. ______________________________ 8. ______________________________

9. ______________________________ 10. ______________________________

SMOKING HISTORY

Do you smoke NOW or have you EVER smoked? □ Yes □ No

If NO, skip to next block. If YES, please mark the following as it applies to you

What do you smoke NOW or did you PREVIOUSLY smoke?

□ Cigarettes	□ Pipes (Hookah, etc.)	□ Cigars
□ E-cigarettes	□ Other:	

Date you STARTED SMOKING____

Date you QUIT SMOKNG____ □ N/A

How much DO YOU NOW smoke or HOW MUCH DID YOU USED TO SMOKE?

(i.e. ½ pack a day for 3 years) ____

ALCOHOL CONSUMPTION

Do you EVER drink alcohol? □ Yes □ No

If yes, estimate amount you drink in a week, month or years' time. ________________________________

Do you feel you have or may have a problem with drinking alcohol? □ Yes □ No

SURGICAL HISTORY

Have you EVER had a surgical procedure or operation (including C-section and oral surgery)? □ Yes □ No

If yes, please list WHAT surgery you had done AND approximately WHEN it was done.

1.____	2. ______________________________________
3. ____	4. ______________________________________
5. ____	6. ______________________________________
7. ____	8. ______________________________________
9. ____	10. _____________________________________

MEDICAL HISTORY
ENT/EYES

Question	Answer
Do you have sinus trouble?	□ Yes □ No
Do you have difficulty breathing through your nose, not due to a cold?	□ Yes □ No □ Sometimes
Have you had any nose bleeds in the last year that was not due to an injury?	□ Yes □ No
Have you EVER been told by a Dr. that you have nasal polyps?	□ Yes □ No □ Unsure
Do you have any ulcers (sores) in your mouth, on your tongue or lips? Where?	□ Yes □ No
Have you had any pain in your tongue in the last 6 months?	□ Yes □ No
Have you had a sore throat in the past year NOT due to a cold?	□ Yes □ No □ Unsure
Do you have any lumps or enlarged glands in your throat or elsewhere? Where?____	□ Yes □ No
Are you hard of hearing or deaf? If yes, which ear(s)?	□ Yes: Right Left □ No

Are your teeth in good repair?	**□ Yes □ No**
Do you wear dentures, partials or have a bridge?	**□ Yes □ No**
Do you have poor vision in one or both eyes?	**□ Yes □ No**
If yes, is your vision correctable by glasses or contacts?	**□ Yes □ No □ N/A**

PULMONARY

Do you have a frequent or daily cough?	**□ Yes □ No**
If yes, when are you most aware of your cough? **□ Mornings □ Day □ Night**	**□ Day & night equally**
Is your cough due to smoking?	**□ Yes □ No □ Unsure**
If you have a cough, do you cough up phlegm?	**□ Yes □ No □ Unsure**
Have you EVER coughed up blood?	**□ No** **□ Yes, more than 6 months ago □ Yes, within the last 6 months** **□ Unsure**
Have you EVER been told by a Dr. that you had pneumonia?	**□ No** **□ Once □ More than once □ Unsure**
Have you EVER been told by a Dr. that you have emphysema?	**□ Yes □ No □ Unsure**
Has a Dr. ever removed fluid from your lungs or chest or have you ever had a collapsed lung?	**□ Yes □ No □ Unsure**
Are you aware of any difficulty breathing while sitting still?	**□ No □ Sometimes** **□ Often □ Unsure**
Do you get short of breath while walking normally on level ground for any distance?	**□ No □ Sometimes** **□ Often**
Do you get short of breath while walking slowly on level ground for any distance?	**□ No □ Sometimes** **□ Often**
Do you get short of breath walking up a hill?	**□ No □ Sometimes** **□ Often**
Do you get short of breath while lying down?	**□ No □ Sometimes** **□ Often □ I must prop my head up**
Have you ever been awakened due to shortness of breath?	**□ No □ Sometimes** **□ Often**
Are you aware of wheezing or noisy breathing when you breathe?	**□ No □ Sometimes** **□ Often**

CARDIOVASCULAR

Have you EVER been told by a Dr. that you have high blood pressure	**□ Yes □ No** **□ I've never checked my blood pressure**
Has a Dr. EVER advised treatment for high blood pressure?	**□ Yes □ No □ Unsure**
Have you EVER been told by a Dr. that you had a blood clot in a vein (phlebitis or thrombophlebitis)?	**□ Yes □ No □ Unsure**
Have you EVER been told by a Dr. that you had a blood clot in an artery?	**□ Yes □ No □ Unsure**
Within the past 6 months, have you taken an anticoagulant med to prevent blood clots?	**□ Yes □ No □ Unsure**

Has a Dr. ever removed fluid from your lungs or chest or have you ever had a collapsed lung? □ Yes □ No □ Unsure

Do you EVER have discomfort or distress in your chest? □ Yes □ No □ Unsure

If yes, does the discomfort occur under any of the following situations?

□ Anger	□ Aggravation	□ Emotional excitement	□ Overeating
□ Running	□ Heavy physical exercise	□ Walking up a hill	□ Walking up stairs
□ Cold weather walking	□ Sexual intercourse	□ None of these	

□ Other, please describe:____

If you have had chest discomfort, which of the following best describes it? (mark all that may apply)

□ Sharp, stabbing or shooting pain	□ Heaviness or pressure	□ Choking feeling	□ Tingling
□ Indigestion	□ Squeezing or tightness	□ Burning	□ Just a pain

□ Other, please describe:____

Have you EVER been told by a Dr. that you have a heart murmur?	□ Yes □ No □ Unsure
Have you EVER been told by a Dr. that you have angina (heart pain)?	□ Yes □ No □ Unsure
Have you EVER been told by a Dr. that you had a heart attack (coronary or MI)?	□ Yes □ No □ Unsure
Have you EVER been told by a Dr. that you have congestive heart failure?	□ Yes □ No □ Unsure
Have you EVER been told by a Dr. that you have an enlarged or abnormal heart?	□ Yes □ No □ Unsure
In the past 6 months have you taken any heart medication?	□ Yes □ No □ Unsure
Has the medicine Nitroglycerin ever been prescribed for you by a Dr.?	□ Yes □ No □ Unsure
Have you ever been told by a Dr. that you have/had abnormal ECG/EKG (heart tracing)?	□ Yes □ No □ Unsure

Which of the following statements best describes the rate (speed) and rhythm of your heart beat? (Mark all that apply)

□ My heart rate seems to be normal.	□ My heart rhythm seems to be normal.
□ My heart rate seems very fast much of the time.	□ I occasionally have episodes of very rapid heart rate, which starts & stops suddenly.
□ My heart rate seems very slow much of the time.	□ My heart rhythm frequently seems irregular
□ None of the above	□ My heart occasionally seems to skip a beat, or to have an extra beat

NEUROLOGICAL

Have you had an episode(s) of fainting or "passing out" at any time in the last year? □ Yes □ No

If Yes, please explain____

Have you had similar fainting episodes prior to this? □ Yes □ No

If Yes, please explain

Do you now have dizziness or dizzy spells? □ Yes □ No

Have you EVER been told by a Dr. that you have migraine headaches? □ Yes □ No

If yes, how frequently? ____

When was your last episode? ____

Do you have a known cause or "trigger" for your migraines □ Yes □ No

If yes, please describe. ____

What do you do to treat the migraine or make it better?______________________________

In the last year, have you had an episode of vision "black out" or temporary loss of vision □ Yes □ No

Have you EVER had a seizure, also called a convulsion or "fit"? □ Yes □ No

If yes, when did you have your last one? ______________________________________

If yes, do you have a known aura associated with them?.. □ Yes □ No

If yes, what is the aura? ____

GASTROINTESTINAL

Within the last 3 months, have you had any type of discomfort in your abdomen or stomach? If yes, please describe. □ Yes □ No

____

Have you EVER been told by a Dr. that you have gastrointestinal problems? □ Yes □ No

If yes, what was your diagnosis? Please mark all that apply from the following:

□ Gastric ulcer □ Gastro-Esophageal Reflux Disease (GERD) □ Duodenal ulcer

□ Colon polyps □ Diverticulitis □ Don't know

□ Other:____

Have you EVER been told by a Dr. that you have now or in the past any of the following?

□ Enlarged liver □ Enlarged spleen □ Tumor in the abdomen

□ Hepatitis □ Jaundice □ None of the above

SKELETAL

Have you EVER broken or fractured a bone or had a joint injury? □ Yes □ No If yes, what bone(s) and/or joints? ______________________

In the past 6 months have you been troubled with backaches? □ Yes □ No

Were you aware of back pain prior to 6 months ago? □ Yes □ No

Are you concerned about your back pain? □ Yes □ No

When you have back pain is it difficult to bend forward or twist side to side? □ Yes □ No

In the past 6 months have you been troubled with neck pain? □ Yes □ No

Were you aware of neck pain prior to 6 months ago? □ Yes □ No

In the past 6 months have you had pain in ANY of your joints? □ Yes □ No

OTHER MEDICAL

Have you EVER been told by a Dr. that you were anemic □ Yes □ No □ Don't understand

Have you EVER been told by a Dr. that you have/had a low white blood cell count? □ Yes □ No □ Don't understand

Have you EVER been told by a Dr. that you have/had a high red blood cell count? □ Yes □ No □ Don't understand

Do your lips or fingertips ever turn blue or white? □ Yes, lips □ Yes, fingertips □ No

When exposed to cold or cold objects, does ANY parts of ANY of your fingers turn white? □ Yes □ No □ Unsure

Do you have any birth defects? □ Yes □ No

If yes, please describe____

If yes, does this interfere with your daily life? □ No □ Yes, slightly □Yes, very much

Do you currently have any piercings in your mouth, tongue or nose? □ Yes □ No

Have you had any tattoos or body piercings done in the last month? □ Yes □ No

Do you have NOW or have you EVER had any of the following conditions or diseases? Please mark all that apply.

□ Bleeding Disorder
□ Underactive Thyroid Disease
□ Glaucoma
□ Rheumatic Heart Disease
□ Overactive Thyroid Disease
□ Leukemia
□ Cancer
□ Herpes Infections (cold sores, genital)
□ Malaria
□ Depression
□ Anxiety
□ None
□ Kidney Disease, Nephritis
□ Goiter
□ Inflammatory Bowel Disease
□ Hypertension
□ Sickle Cell Disease or Trait
□ Gout
□ Rheumatoid arthritis
□ Hepatitis
□ Claustrophobia
□ Hereditary Disease ________________________________
□ Other, that is not listed ______________________________
□ Raynaud's Disease
□ Diabetes
□ Mitral Valve Prolapse
□ Stroke
□ Congenital Heart Defect
□ Osteoarthritis
□ Positive Skin Test for TB
□ HIV
□ ADHD

FAMILY MEDICAL HISTORY

Were you adopted or in foster care? □ Yes □ No

Do you know any of your birth family's medical history? □ Yes □ No

Answer the following questions as it relates to your birth family.

Is your mother alive? □ Yes □ No □ Unsure
If no, what age did she die?________________
Why did she die?____ □ Unknown

Is your mother's mother alive? □ Yes □ No □ Unsure
If no, what age did she die?________________
Why did she die?____ □ Unknown

Is your mother's father alive? □ Yes □ No □ Unsure
If no, what age did he die?_________________
Why did he die?____ □ Unknown

Is your <u>father</u> alive? □ Yes □ No □ Unsure
If no, what age did he die?________________
Why did he die?____ □ Unknown

Is your <u>father's mother</u> alive? □ Yes □ No □ Unsure
If no, what age did she die?________________
Why did she die?____ □ Unknown

Is your <u>father's father</u> alive? □ Yes □ No □ Unsure
If no, what age did he die?_________________
Why did he die?____ □ Unknown

<u>Please identify any relative and Medical Condition in the following chart with an "X".</u>

To the best of your knowledge, have any of your <u>blood relatives</u> EVER had any of the following conditions? □ Yes □ No

If your grandparents, aunts or uncles have or have had any of these conditions, please mark which side of family (Mother's side, Father's side).

Medical condition	Mother	Father	Mother's side	Father's side	My Siblings	My children
Heart Attack						
Heart Disease (i.e. Angina, Coronary Artery Disease, Other Heart Disease						
Heart Defect (congenital)						
High Blood Pressure						
Stroke						
Bleeding Disorders (Hemophilia, etc.)						
Kidney Disease						
Other Medical Condition(s)						

****

<u>Men</u>, you have completed your medical history questionnaire. Thank you!

<u>Women</u>, please continue to the next page.

THIS PAGE IS FOR WOMEN ONLY

Have you reached menopause? ……………………………………………………………□ Yes □ No □ Unsure

If you answered Yes, please skip to the next block.

If you answered No or Unsure, please continue with the following questions in this block:

At this time, do you think you may be pregnant? ……………………… …………...……...…….□ Yes □ No

Was your last period more than 4 weeks ago? ………………………………………...…□ Yes □ No □ Unsure

If you take Birth Control, does it change your menstrual cycles?............................... □ Yes □ No □ Unsure

Are you trying to get pregnant? …………………………………………………………...…….□ Yes □ No

Are you currently breastfeeding? ……………………………….………….………………...□ Yes □ No

Have you EVER been pregnant?_…...……………………...……………………………..□ Yes □ No □ Unsure

If Yes, how many times were you pregnant? _____________

How many children were born alive? _____________

Did you have any children born prematurely? …..…………...……………..□ Yes □ No □ Unsure

If Yes, how many? ________________

Are you aware of any lumps in your breast(s) right NOW? …........…□ Yes □ No □ I haven't noticed any.

Have you EVER had a lump in your breast which you do not have now? …………..…□ Yes □ No □ Unsure

If yes, what was the diagnosis by a Dr.?

□ Benign (non-cancerous) □ Malignant (cancerous)

□ Unsure

What happened to the lump?

□ Disappeared by itself □ Disappeared with treatment

□ Removed by surgery

YOU ARE DONE!!!! Thank you!