Patient ID: ____________________
Year of Birth: _________________
Date: ________________________

HEALTH HISTORY AND BEHAVIORS QUESTIONNAIRE

Body Scan International is dedicated to providing a non-invasive early disease detection system with your optimal health and longevity in mind. The following Health History and Behaviors Questionnaire will enable us to be the best partners we can on this pathway to optimal health. We would like you to take some time before your visit to our Center to complete this questionnaire and bring it with you to your appointment at Body Scan International. Your information will remain confidential.

WOMEN ONLY: IF YOU ARE OR THINK YOU ARE CURRENTLY PREGNANT, PLEASE NOTIFY THE RECEPTIONIST IMMEDIATELY

Health History:

Height:_________ Weight:__________

1. Date of last stress test:________________ Type? EKG □ ECHO □ THALLIUM/ CARDIOLYTE □

2. Date of last mammogram:____

3. Allergies to medications:____

4. Have you had any surgeries? If so please list:
   ____ Date:_________
   ____ Date:_________
   ____ Date:_________
   ____ Date:_________
   ____ Date:_________

5. What is your main reason for having this test?
   ____
   ____
   ____
   ____

6.. Has your doctor ever told you that you have (or had) angina (chest pain generally provoked upon exertion, relieved upon rest)?
   θ Yes
   θ No
   θ Not sure

7. If so, do you currently have (e.g. weekly or more frequent) such chest pain?
   θ Yes
   θ No

8. Has your doctor ever told you that you have had a heart attack?
θ Yes
θ No
θ Not sure

9. If so, when did your heart attack(s) occur (month, year), and where were you hospitalized?
Date____
Hospital______________________________City_____________State___

Date____
Hospital______________________________City_____________State___

10.. Have you ever had heart bypass surgery?
θ Yes
θ No

11. If yes, please list date(s) and hospital(s) where performed:
Date____
Hospital______________________________City_____________State___

12. Have you ever had a balloon angioplasty of the heart (PTCA)?
Indicate if:
θ Yes
θ No
θ Atherectomy
θ Stent
θ Not Sure

13. If yes, please list date(s) and hospital(s) where performed :
Date____
Hospital_______________________________City____________State___

14. Have you ever had surgery to remove blockage from blood vessels in you neck or legs?
θ Yes
θ No

15. If yes, please describe surgery and list date(s) and hospital(s) where performed:
Date____
Hospital________________________________City___________State____

16. Have you ever had any other type of heart disease (e.g. heart valve disease, heart failure, abnormal heart rhythms such as atrial fibrillation)?
θ Yes
θ No

17. If yes, please describe the condition(s) the best you can, and approximate the day it (they) began or were diagnosed:

Condition____________________________
____
Date began or diagnosed_______________

18. Has your doctor ever told you that you have had a stroke? θ Yes θ No

19. If so, when did your stroke(s) occur (month, year), and where were you hospitalized?
Date____
Hospital______________________________City__________State_____

Date____
Hospital______________________________City__________State_____

Date____
Hospital______________________________City__________State_____

20. Were you ever told by your doctor that you had a "mini stroke" or transient ischemic attack? θ Yes θ No

21. Has a doctor ever told you that you have any of the other following conditions?

Migraine Headaches	_____	Pulmonary/Lung disease	_____
Stomach ulcers	_____	Rheumatological/Musculoskeletal	_____
Arthritis	_____	Endocrine disorder	_____
Osteoporosis	_____	Liver disease	_____
Gastrointestinal disorder	_____	Drug abuse/addiction	_____
Allergies	_____	Psychiatric	_____
Kidney disease	_____	Reproductive disorder	_____
Phobia, Panic Attack	_____	Seizure	_____

Other: ________________________

22. If any of the above is checked, please describe: ____
____
____Duration___________________

23. Have you been diagnosed with cancer? θ Yes θ No

24. If yes, what type or location? ____

25. Has your doctor ever told you that you have high blood pressure (or "hypertension")? θ Yes, currently θ Yes, in the past only θ No, never

26. If yes, please list medication(s) that you are <u>currently</u> taking for your high blood pressure (if none, state "none"): ____
____

27. Has your doctor ever told you that you have high cholesterol or triglycerides? θ Yes, currently θ Yes, in the past only θ No

28. If yes, please list medication(s) that you are currently taking for your blood cholesterol or triglycerides (if none, state "none"): ____

29. Has your doctor ever told you that you have diabetes?
- θ Yes
- θ No
- θ Not sure

30. If yes, at what age did you first learn you had diabetes? Age: _____

31. Are you currently taking insulin to control your diabetes?
- θ Yes
- θ No

32. If you are currently taking other medications for your diabetes, please list them:__________________
____

Risk Factors

33. Have you smoked 100 cigarettes or more in your lifetime?
- θ No
- θ Yes, currently
- θ Yes, in the past, quit

smoke

34. If you quit, at what age did you quit? Age: _____

35. If currently/previously smoking, how many cigarettes, on average, do/did you smoke per day? _____cigarettes
For approximately how many years? _____years

36. Did any parent or sibling (or blood related uncle/aunt) have a history of any of the following? Please indicate by completing the following:

	Family member(s)	Age first occurrence
Cancer (specify):____________	________________	_________________
Diabetes:	________________	_________________
Heart attack:	________________	_________________
Angioplasty or bypass surgery	________________	_________________

37. Are you currently, or have you previously, taken aspirin?
- θ Yes, every day or almost every day
- θ Yes, about every other day
- θ Yes, occasionally
- θ No, never

38. If yes, for what reason(s) (check all that apply):

- θ Only for aches and pains, including headaches
- θ To prevent heart attacks, other heart disease, strokes
- θ Other reasons (write these in):_________________

39. If yes, when do you take aspirin, how much do you take in one day?

- θ Less than one "baby aspirin"
- θ One "baby aspirin"
- θ One adult aspirin
- θ Two or more adult aspirins

40. The next questions provide a simple way to measure how many servings of fruit and vegetables you normally eat. Please blacken in the answer showing how often you ate or drank each of these foods in the past month. (Please blacken only 1 answer for each item.)

		Never	1-3 times per month	1-2 times per week	3-4 times per week	5-6 times per week	1 time per day	2 times per day	3 times per day	4 times per day
a.	100% orange juice or grapefruit juice fruit drinks	θ	θ	θ	θ	θ	θ	θ	θ	θ
b.	Green salads (with or without other vegetables)	θ	θ	θ	θ	θ	θ	θ	θ	θ
c.	French fries or fried potatoes Baked boiled or mashed potatoes	θ	θ	θ	θ	θ	θ	θ	θ	θ
d.	About how many servings of vegetables did you eat, not counting salad or potatoes	θ	θ	θ	θ	θ	θ	θ	θ	θ
e.	About how many servings of fruit did you eat, not counting juices	θ	θ	θ	θ	θ	θ	θ	θ	θ

41. Are you currently taking any of the following on a regular basis (i.e. MORE than one day per week, on average)?
If yes, for how many years?

Beta carotene: θ Yes for _____ years θ No

Vitamin E supplements
(excluding multiple vitamins) θ Yes for _____ years θ No

Folic acid supplements
(excluding multiple vitamins) θ Yes for _____years θ No

Multiple Vitamins θ Yes for _____years θ No

Anticoagulants (blood thinners)
(e.g. Coumadin or Heparin) θ Yes for _____ years θ No

Immunosuppressive drugs (e.g. Prednisone)

- θ Yes, currently
- θ Yes, only in the past For ____months, ____yrs.
- θ No, never

Estrogen replacement therapy (women only)

- θ Yes for _____ years
- θ No

Birth control pills (women only)

- θ Yes, currently
  for how long? _____
- θ Yes, only in the past
- θ No, never

42. How many drinks per day/week, on average, have you consumed, OVER THE LAST YEAR?
(1 drink = 1 glass, bottle or can of beer, one 4 oz. glass of wine, or one drink or shot of liquor)

- θ None
- θ Less than 3 drinks/month
- θ One drink per week
- θ 2-4 drinks per week
- θ 5-6 drinks per week
- θ One drink per day
- θ 2-3 drinks per day
- θ 4 or more drinks/day

43. How often do you engage in aerobic physical activity at least 30 minutes at a time (include brisk walking outdoors, swimming, aerobics, cycling, running, hiking, racquetball, etc.)?

- θ rarely/never
- θ less than once/week
- θ once/week
- θ 2-3 times/week
- θ 4-6 times/week
- θ daily

44. What is the highest level of education you completed?

- θ Did not finish high school
- θ Completed high school
- θ Some college or trade school
- θ Completed 4 year college degree
- θ Graduate school or higher

45. Present household total income range:

θ	Under $18,999	(1)	θ	$60,000 – 79,999	(4)
θ	$19,000 - 39,999	(2)	θ	$80,000 – 99,999	(5)
θ	$40,000- 59,999	(3)	θ	Over $100,000	(6)

46. How do you describe your racial or ethnic group?

θ White, Non-Hispanic
θ Latino or Hispanic (Ancestry is Mexican, Cuban, Puerto Rican, Central American or South American)
θ Black or African-American
θ Asian or Pacific Islander (Ancestry is Chinese, Indo-Chinese, Korean, Japanese, Pacific Islander, or Vietnamese)
θ Native American or Alaskan Native
Other Specify: ____

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the appropriate blank. If you are unsure about how to answer a question, please give the best answer you can.

47. In general, would you say your health is:

θ Excellent
θ Very good
θ Good
θ Fair
θ Poor

The following items are about activities you might do during a typical day. Does your health now limit you these activities? If so, how much?

48. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?

θ Yes, limited a lot
θ Yes, limited a little
θ No, not limited at all

49. Lifting or carrying groceries?

θ Yes, limited a lot
θ Yes, limited a little
θ No, not limited at all

50. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

A. Accomplished less than you would like?
- θ Yes
- θ No

B. Were limited in the kind of work or other activities?
- θ Yes
- θ No

51. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

A. Accomplished less than you would like?
- θ Yes
- θ No

B. Didn't do work or other activities as carefully as usual?
- θ Yes
- θ No

52. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
- θ Not at all
- θ A little bit
- θ Moderately
- θ Quite a bit
- θ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks:

53. Have you felt calm and peaceful?
- θ All of the time
- θ Most of the time
- θ A good bit of the time
- θ Some of the time
- θ A little of the time
- θ None of the time

54. Did you have a lot of energy?
- θ All of the time
- θ Most of the time
- θ A good bit of the time
- θ Some of the time
- θ A little of the time
- θ None of the time

55. Have you felt downhearted and blue?

- θ All of the time
- θ Most of the time
- θ A good bit of the time
- θ Some of the time
- θ A little of the time
- θ None of the time

56. In the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

- θ All of the time
- θ Most of the time
- θ Some of the time
- θ A little of the time
- θ None of the above

57. Now, we would like to ask you a few general questions.

0	1	2	3	4
Never	Almost Never	Sometimes	Fairly Often	Very Often

In the last month, how often have you felt that you were unable to control the important things in your life? _______

In the last month, how often have you felt confident about your ability to handle your personal problems? _______

In the last month, how often have you felt that things were going your way? _______

In the last month, how often have you felt that difficulties were piling up so high that you could not overcome them? _______

HEALTH PRACTICES AND ATTITUDES

Take a look at the "Ladder of Health" below. Each sentence corresponds to a number. Pick **one** step on the ladder below which best fits where you are right now. **CHOOSE ONE NUMBER** . . .

As you think about your overall health, would you say:

	MOST HEALTHY
I am completely satisfied with my current health habits	10
I have made some healthy changes, but I need to keep working on it	9
I have begun to make some healthy changes	8
I plan to make healthy changes in the next 30 days	7
I plan to make healthy changes in the next 6 months	6
I often think about making healthy changes, but I have no plans	5
I sometimes think about making healthy changes, but I have no plans	4
I rarely think about making healthy changes and I have no plans	3
I do not think about the need to make healthy changes and I have no plans	2
I have decided not to make healthy changes	1
	LEAST HEALTHY

Now, look at each of the six ladders below one at a time. Reach each heading, **<u>choose one</u>** number which best fits where you are with each health habit at this time.

	Reducing fat in my diet (e.g. taking skin off chicken; not adding margarine or butter to vegetables, etc.)	Increasing fruits/vegetables in my diet to at least 5 per day	Managing stress in my life (e.g., balancing work & family)
	MOST HEALTHY	MOST HEALTHY	MOST HEALTHY
I have <u>made</u> healthy changes and am completely satisfied with my current health habits.	10	10	10
I have made changes but I need to <u>keep working</u> on it	9	9	9
I have <u>begun</u> to make changes	8	8	8
I plan to make changes in the next <u>30 days</u>	7	7	7
I plan to make changes in the next <u>6 months</u>	6	6	6
I <u>often</u> think about making changes but I do not have any plans	5	5	5
I <u>sometimes</u> think about making changes, but I do not have any plans	4	4	4
I <u>rarely</u> think about changing and I do not have any plans	3	3	3
I do <u>not</u> think about the need to make healthy changes	2	2	2
I have decided <u>not</u> to make changes	1	1	1
	LEAST HEALTHY	LEAST HEALTHY	LEAST HEALTHY

	For Smokers Quitting Cigarette for Good	Increasing physical activity to at least 30 minutes of moderate exercise 5 days per week.	Achieving a desirable body weight
	MOST HEALTHY	MOST HEALTHY	MOST HEALTHY
I have made healthy changes and am completely satisfied with my current health habits.	10	10	10
I have made changes but I need to keep working on it	9	9	9
I have begun to make changes	8	8	8
I plan to make changes in the next 30 days	7	7	7
I plan to make changes in the next 6 months	6	6	6
I often think about making changes but I do not have any plans	5	5	5
I sometimes think about making changes, but I do not have any plans	4	4	4
I rarely think about changing and I do not have any plans	3	3	3
I do not think about the need to make healthy changes	2	2	2
I have decided not to make changes	1	1	1
	LEAST HEALTHY	LEAST HEALTHY	LEAST HEALTHY

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE