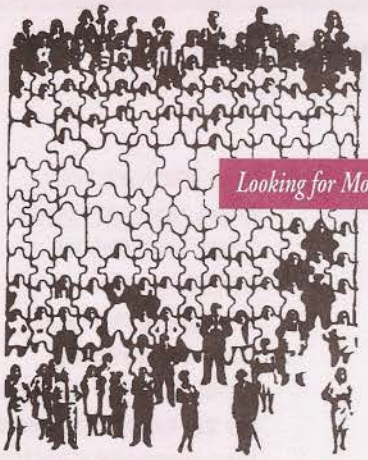

CLUE II

STUDY NO.

0 0 0 0 0
1 1 1 1 1
2 2 2 2 2
3 3 3 3 3
4 4 4 4 4
5 5 5 5 5
6 6 6 6 6
7 7 7 7 7
8 8 8 8 8
9 9 9 9 9

Please check the information above and correct any mistakes.

Is the birthdate indicated above correct?

- ○ No → If no, please write correct date. ___/___/___ (MONTH DAY YEAR)
- ○ Yes, birth date is correct.

If this person is DECEASED, please provide the date of death: ___/___/___ (MONTH DAY YEAR)

INSTRUCTIONS

USE A NO. 2 PENCIL ONLY

THIS FORM IS DESIGNED TO BE READ BY OPTICAL SCANNING EQUIPMENT, SO IT IS IMPORTANT THAT YOU FOLLOW THESE DIRECTIONS:

1. Use **NO. 2 PENCIL**.
2. Make no stray marks on the survey.
3. Fill the circle completely with a dark mark. Please mark this way: ●
4. Mark a circle for each question.
5. Erase completely to change a response.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL OUR OFFICE AT (301) 797-3589.

PLEASE COMPLETE THE SURVEY AND RETURN IT IN THE ENCLOSED POSTAGE-PAID ENVELOPE

PLEASE DO NOT WRITE IN THIS AREA

4957

10/2003

1 **How long have you lived at your current address?**

- ○ Less than 1 year
- ○ 1–2 years
- ○ 3–5 years
- ○ 6–9 years
- ○ 10–14 years
- ○ 15–19 years
- ○ 20–24 years
- ○ 25 or more years

2 **How tall are you (without shoes)?**
(Write in number, then fill in circles)

Feet	Inches	
0	0	0
1	1	1
2		2
3		3
4		4
5		5
6		6
7		7
		8
		9

Note: It is important that you write in your height in addition to completing the corresponding circles. This allows us to confirm that the correct circles have been filled in.

3 **How much do you weigh?**
(Write in number, then fill in circles)

POUNDS		
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
	6	6
	7	7
	8	8
	9	9

Note: It is important that you write in your weight in addition to completing the corresponding circles. This allows us to confirm that the correct circles have been filled in.

4 **How many grades (years) of school, including college and post-graduate education, have you completed?**
(Write in grade, then fill in numbers)

GRADES	
0	0
1	1
2	2
	3
	4
	5
	6
	7
	8
	9

Note: It is important that you write in the grades completed in addition to completing the corresponding circles. This allows us to confirm that the correct circles have been filled in.

HEALTH HISTORY

5 **In general, would you say your health is:**

○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

---

6 **Compared to two years ago, how would you rate your health now?**

○ Better ○ Same ○ Worse

---

7 **Compared to two years ago, does pain usually interfere with your normal work (including both work outside the home and housework)?**

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

---

8 **During the past year, how much of the time has your physical health interfered with your social activities (like visiting with friends, relatives, etc.)?**

○ None of the time ○ A little of the time ○ Some of the time

○ Most of the time ○ All of the time

---

9 **During the past year, how much of the time has your emotional health/well-being interfered with your social activities?**

○ None of the time ○ A little of the time ○ Some of the time

○ Most of the time ○ All of the time

---

10 **Do you have difficulty with any of the following?**
Mark all that apply.

○ Walking ○ Preparing meals ○ Bathing

○ Taking medications ○ Dressing ○ Managing your finances

○ Eating ○ Using the telephone ○ Light housekeeping

○ Vision ○ Incontinence (poor bladder control) ○ Short-term memory

PLEASE DO NOT WRITE IN THIS AREA

11 **Have you ever been told by a doctor or other health professional that you have any of the conditions listed below? (If you don't recognize the term below, you probably haven't been diagnosed with it.) Mark either no or yes for each item. If Yes, write in the age when you were first diagnosed.**

	No	Yes	Age when first diagnosed (Please write in)
Heart or Blood Pressure			
Diabetes	○	○	
High blood pressure (excluding during pregnancy)	○	○	
High cholesterol	○	○	
High triglycerides	○	○	
Heart attack (myocardial infarction)	○	○	
Angina pectoris	○	○	
Stroke	○	○	
TIA (transient ischemic attack)	○	○	
Peripheral artery disease or claudication of legs (pain with walking or exercise) (not varicose veins)	○	○	
Arrythmias	○	○	
Blood clots (deep vein thrombosis)	○	○	
Congestive heart failure	○	○	
Bones			
Herniated lumbar disk	○	○	
Osteoporosis	○	○	
Hip fracture	○	○	
Wrist or Colles' fracture	○	○	
Vertebral body fracture	○	○	
Thyroid			
Hyperthyroid/Graves disease	○	○	
Hypothyroid disease	○	○	
Other Thyroid disease	○	○	

	No	Yes	Age when first diagnosed (Please write in)
Arthritis/Autoimmune Disease			
Rheumatoid arthritis	○	○	
Osteoarthritis	○	○	
Systemic lupus	○	○	
Gout	○	○	
Gastrointestinal			
Colon or rectal polyp (benign)	○	○	
Gallbladder disease/gallstones	○	○	
Gastric or duodenal ulcer	○	○	
Hiatal hernia	○	○	
Chronic indigestion	○	○	
Diverticulitis/diverticulosis	○	○	
Ulcerative colitis/Crohn's disease	○	○	
Barrett's esophagus	○	○	
Cancer			
Bladder	○	○	
Breast	○	○	
Cervix	○	○	
Cervix in situ	○	○	
Colon or rectum	○	○	
Esophageal	○	○	
Kidney	○	○	
Leukemia	○	○	
Lung	○	○	
Lymphoma or Hodgkins	○	○	
Melanoma	○	○	

	No	Yes	Age when first diagnosed (Please write in)
Cancer (continued)			
Oral cavity	☐	☐	_____
Ovary	☐	☐	_____
Pancreas	☐	☐	_____
Prostate	☐	☐	_____
Skin-basal cell carcinoma	☐	☐	_____
Skin-squamous cell carcinoma	☐	☐	_____
Stomach	☐	☐	_____
Thyroid	☐	☐	_____
Uterus or endometrium	☐	☐	_____
Other (please specify): _____	☐	☐	_____
Kidney/Bladder			
End stage renal disease	☐	☐	_____
Kidney stones	☐	☐	_____
Lung			
Asthma	☐	☐	_____
Emphysema or chronic bronchitis	☐	☐	_____
Neurologic Conditions			
Migraine headaches	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Parkinson's disease	☐	☐	_____
ALS – Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	☐	☐	_____
Dementia	☐	☐	_____
Teeth			
Peridontal disease (gum disease)	☐	☐	_____
Tooth loss	☐	☐	_____

	No	Yes	Age when first diagnosed (Please write in)
Eyes			
Macular degeneration of the retina	☐	☐	
Cataract	☐	☐	
Glaucoma	☐	☐	
Breast/Gynecologic Conditions			
Fibrocystic disease of the breast or other benign breast disease	☐	☐	
Endometriosis	☐	☐	
Uterine fibroids	☐	☐	
Infertility	☐	☐	
Prostate			
Enlarged prostate (Benign prostatic hyperplasia)	☐	☐	
Male Infertility	☐	☐	
Other Major Medical Condition			
Other (specify condition)_____	☐	☐	

	No	Yes	Age at surgery (Please write in)
Surgical Procedures			
Cardiac catheterization (angiogram)	☐	☐	
Coronary angioplasty or bypass	☐	☐	
Carotid or cerebral angiogram	☐	☐	
Carotid surgery – endarterectomy	☐	☐	

12 **Please list medications including aspirin, vitamins, supplements that you take on a regular basis.**

THANK YOU

PLEASE CHECK TO MAKE SURE YOU HAVE NOT ACCIDENTALLY SKIPPED ANY PAGES.

PLEASE RETURN THE BOOKLET IN THE POSTAGE-PAID ENVELOPE

Johns Hopkins Research Center
P.O. Box 2067
Hagerstown, MD 21742-2067

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