



# HEALTH PROFESSIONALS FOLLOW-UP STUDY

1. Please WRITE in your date of birth:  /  /   
MONTH DAY YEAR

2. Your CURRENT weight:    lbs.

3. Do you currently smoke a pipe, cigar or cigarettes?  
 No  Yes

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

4. Since January 1, 1994, have you had any of the following professionally diagnosed conditions or procedures?

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"	YEAR OF DIAGNOSIS				
	BEFORE 1994	1994	1995	1996 OR LATER	
High blood pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
Diabetes mellitus	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
Elevated cholesterol	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3
Elevated triglycerides	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4
Myocardial infarction (heart attack)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5
↳ Hospitalized for this MI? <input type="checkbox"/> No <input type="checkbox"/> Yes					6
Angina pectoris	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7
↳ Confirmed by an angiogram? <input type="checkbox"/> No <input type="checkbox"/> Yes					8
Coronary artery bypass or angioplasty	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9
Pulmonary embolus	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
TIA (Transient Ischemic Attack)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11
Stroke (CVA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12
Carotid artery surgery	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13
Intermittent claudication	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14
Surgery for arterial disease of the leg (e.g., femoral artery)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15
Aortic aneurysm	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16
Glaucoma	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17
Cataract	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18
Cataract extraction	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19
Macular degeneration	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20
Rheumatoid arthritis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21
Other arthritis (e.g., osteoarthritis)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22
Hip replacement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23
Fracture of hip or forearm	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"	YEAR OF DIAGNOSIS				
	BEFORE 1994	1994	1995	1996 OR LATER	
Colonoscopy or Sigmoidoscopy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25
Diverticulitis or Diverticulosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26
Colon or rectal polyp	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27
Cancer of the colon or rectum	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28
Basal cell skin cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29
Squamous cell skin cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30
Melanoma	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31
Prostate enlargement, surgically treated (e.g., TURP)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32
Prostate cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33
Lymphoma or leukemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34
Other cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35
↳ Please specify site and year: <input type="text"/>					36
Parkinson's disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37
Periodontal disease with bone loss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38
Leukoplakia or other oral precancerous lesions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39
Alcohol dependence problem	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40
Gallbladder removal	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41
Kidney stones	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42
Gastric or duodenal ulcer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43
Ulcerative colitis/Crohn's disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44
Asthma	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45
Emphysema or chronic bronchitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46
Pneumonia (X-ray confirmed)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47
Other major illness?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48

Please specify fracture site and circumstances on back. Also, please continue at top of next column.

↳ DIAGNOSIS  DATE