



# 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

4. Since January 1, 1996, have you had any of the following professionally diagnosed conditions or procedures?

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"	YEAR OF DIAGNOSIS				
	BEFORE 1996	1996	1997	1998 OR LATER	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3
Elevated triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4
Myocardial infarction (heart attack)	<input 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 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 coronary angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9
Pulmonary embolus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
TIA (Transient Ischemic Attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11
Stroke (CVA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12
Carotid artery surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13
Intermittent claudication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14
Surgery or angioplasty for arterial disease of the leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15
Aortic aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18
Cataract extraction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21
Other arthritis (e.g., osteoarthritis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22
Hip replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23
Fracture of hip or forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24

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

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"	YEAR OF DIAGNOSIS				
	BEFORE 1996	1996	1997	1998 OR LATER	
Colonoscopy or Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25
Diverticulitis or Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26
Colon or rectal polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27
Cancer of the colon or rectum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28
Basal cell skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29
Squamous cell skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31
Prostate enlargement, surgically treated (e.g., TURP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33
Lymphoma or leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34
Other cancer	<input 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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37
Periodontal disease with bone loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38
Leukoplakia or other oral precancerous lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39
Alcohol dependence problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40
Gallbladder removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42
Gastric or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43
Ulcerative colitis/Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45
Emphysema or chronic bronchitis (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46
Pneumonia (X-ray confirmed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47
Other major illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48

DIAGNOSIS  DATE