QM /1

ID Label /2-5

CHAMPS

Community Healthy Activities Model Program for Seniors

MEDICAL HISTORY QUESTIONNAIRE

Please read these instructions carefully. This questionnaire is about your medical conditions and problems, medications and treatments. The information will help us in developing your physical activity program.

- There are **two main types of questions:**
  ⇒ Questions where you need to circle YES or NO as the question applies to you; and

  ⇒ Questions where an answer has not been supplied. You should write your answer in the space provided.

- Feel free to **write any comments** you have in the space provided at the end of the questionnaire or next to questions on which you have comments. Please **ignore the shaded sections** in the right hand margin; they relate to coding of information for the computer.

- **Please bring your completed questionnaire to your next appointment with the CHAMPS staff.**

- This questionnaire will take about **15 to 20 minutes** to complete. If you are uncertain about how to answer some of the items, bring it with you to your next CHAMPS appointment and we will assist you.

Today's Date: _____/_____/_____
month day year /6-11

Institute for Health & Aging
University of California San Francisco

Center for Research in Disease Prevention
Stanford University

Statement of Confidentiality

All information that would permit identification of individuals will be regarded as strictly confidential, will be used only for purposes of evaluating the study, and will not be disclosed or released for any other purposes without prior consent, except as required by law.

Instructions: **The following questions are about your medical background. Please answer YES or NO for each question.**

Do you now have any of the following conditions or problems?			
Trouble seeing, even with glasses or contact lenses?	YES	NO	/12
Trouble hearing, even with a hearing aid?	YES	NO	/13
Arthritis or other joint problems?	YES	NO	/14
Back or spine problems?	YES	NO	/15
Osteoporosis?	YES	NO	/16
Fractures (broken bones) such as a hip fracture, compression fracture or spine fracture?	YES	NO	/17
Pain that is made worse by moving around?	YES	NO	/18
Shortness of breath?	YES	NO	/19
Pains in your heart or chest?	YES	NO	/20

Have you ever experienced the following **while walking, climbing stairs, working or exercising?**			
• Chest pain	YES	NO	/21
• Faintness	YES	NO	/22
• Light-headedness or dizziness	YES	NO	/23
• Leg pain	YES	NO	/24
• Heart beat irregularities	YES	NO	/25
Has your doctor ever said you have heart trouble?	YES	NO	/26
Has your doctor ever said you have congestive heart failure?	YES	NO	/27
Has your doctor ever told you to restrict your physical activity because of a physical or medical problem?	YES	NO	/28
Have you fallen in the past 12 months? Falling includes falling on the ground or at some other level such as a chair. If **YES**, how many times have you fallen in the last 12 months?	YES ____	NO times	/29 /30-31
Are you <u>now</u> receiving treatment for a mental health condition such as depression or anxiety?	YES	NO	/32
Do you <u>now</u> have any of the following conditions or problems?			
Spells of dizziness, feeling faint or loss of consciousness?	YES	NO	/33
Paralysis, stroke, or other neurological problems?	YES	NO	/34
Parkinson's disease?	YES	NO	/35

Do you <u>now</u> have any of the following conditions or problems?

Digestive or stomach problems such as chronic inflamed bowel, hiatal hernia, enteritis, colitis, ulcers, etc.?	YES	NO	/36
Kidney or liver disease?	YES	NO	/37
Asthma, chronic bronchitis or emphysema?	YES	NO	/38
High blood pressure (hypertension)? If **YES**, what is your usual blood pressure: _____ / _____ How is it being controlled? Please explain: _____ _____ _____	YES	NO	/39 /40-45 /46-51
Diabetes? If **YES**, how is it being controlled? Please explain: _____ _____ _____	YES	NO	/52 /53-58
Cancer diagnosed in the last 3 years? If **YES**, what type of cancer? Please explain: _____ _____ _____	YES	NO	/59 /60-65
If **YES**, are you <u>now</u> receiving treatment for cancer?	YES	NO	/66

Do you have any other major health problems or conditions not mentioned above? If **YES**, please explain: _____ _____ _____	YES	NO	/67 /68-73
Is there a good physical reason not mentioned above why you should not follow a physical activity program, even if you wanted to? If **YES**, please explain: _____ _____ _____	YES	NO	/74 /75-80

Instructions: The next set of items ask for information about medications you are now taking.

Sometimes people have difficulty completing this section. If you would like assistance from the CHAMPS staff, please bring all of your prescription medications bottles to your next appointment with our staff. We will then write down the names of the medication and immediately return them to you. If you would prefer to complete this information on your own, please complete the information below.

Please list the names of the prescription medications you have been taking regularly for at least the past month. [Please PRINT legibly]

Drug #1: _____

Drug #2: _____

Drug #3: _____

Drug #4: _____

Drug #5: _____

Drug #6: _____

Drug #7: _____

Drug #8: _____

Drug #9: _____

Drug #10: _____

Are you receiving any other type(s) of treatment(s) not previously mentioned?
If **YES,** please list the treatment(s): _____

_____

_____

If you have any comments that you would like to share with us, please feel free to write them below. Please use the back of this page if you need more room to write.

_____

_____

_____

_____

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Thank you!