

SMU Health Questionnaire

Age _____ Sex _____ Marital Status _____

Religious Upbringing: Catholic _____ Protestant _____ Jewish _____ Other _____

Highest level of education that you have completed _____

Place a check in front of every health problem you have had during the last year. Be sure to check every health problem you used to have but now control with medication or treatment:

- | | |
|--|---|
| <input type="checkbox"/> cold or flu | <input type="checkbox"/> significant weight gain |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> significant weight loss |
| <input type="checkbox"/> anemia | <input type="checkbox"/> headache (not migraine) |
| <input type="checkbox"/> fainting | <input type="checkbox"/> low blood pressure (hypoglycemia) |
| <input type="checkbox"/> hernia | <input type="checkbox"/> high blood pressure (hypertension) |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> arthritis or rheumatism |
| <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> abdominal or stomach pain |
| <input type="checkbox"/> rash | <input type="checkbox"/> gall bladder problems |
| <input type="checkbox"/> appendicitis | <input type="checkbox"/> lung or respiratory problems |
| <input type="checkbox"/> paralysis | <input type="checkbox"/> heartbeat irregularity |
| <input type="checkbox"/> ulcer | <input type="checkbox"/> high cholesterol |
| <input type="checkbox"/> skin cancer | <input type="checkbox"/> chronic back problem |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> kidney or urinary tract problems |
| <input type="checkbox"/> constipation | <input type="checkbox"/> eye problem (sty, cataract) |
| <input type="checkbox"/> ear ache | <input type="checkbox"/> thrombosis (blood clots) |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> water retention (bloating) |
| <input type="checkbox"/> asthma | <input type="checkbox"/> serious dental problems (incl. gums) |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> angina or chest pain |
| <input type="checkbox"/> colitis | <input type="checkbox"/> migraine headache |
| <input type="checkbox"/> seizures | <input type="checkbox"/> thyroid problem |
| <input type="checkbox"/> bulimia | <input type="checkbox"/> anorexia nervosa |
| <input type="checkbox"/> allergies | <input type="checkbox"/> grinding of teeth or TMJ |
| <input type="checkbox"/> blackouts | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> depression | <input type="checkbox"/> breast cancer |
| <input type="checkbox"/> indigestion | <input type="checkbox"/> other cancer |
| <input type="checkbox"/> severe acne | <input type="checkbox"/> benign tumor |
| <input type="checkbox"/> mononucleosis | <input type="checkbox"/> liver problem |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> sexual problems (impotency, frigidity) |
| <input type="checkbox"/> pregnancy | <input type="checkbox"/> venereal disease (incl. herpes) |
| <input type="checkbox"/> endometriosis (cramps) | <input type="checkbox"/> pre-menstrual syndrome |
| <input type="checkbox"/> obesity | <input type="checkbox"/> other reproductive (cysts, prostate) |
| <input type="checkbox"/> other health problems; Specify: | |

How many days during the last year were you hospitalized for each of the following:

surgery _____ childbirth _____ psychological problems _____
injury _____ illness _____ drug/alcohol problems _____