U.C. ID CODE #:

FERNALD MEDICAL MONITORING PROGRAM

2007 QUESTIONNAIRE AM

INFORMATION UPDATE

The primary objectives of the Fernald Medical Monitoring Program (FMMP) are to provide a complete evaluation of your current health and to reduce the chance that you will develop disease in the future. In order to achieve those objectives, it is important that we maintain an up-to-date medical record on each program participant.

Thank you for providing this information update. If you have any questions, please call the Fernald Medical Monitoring Program office at 513-874-1074.

ADDRESS AND PHONE INFORMATION

What title should we use for you? ___ Mr. ___ Mrs. ___ Miss ___ Ms.

Is this your correct address and phone number?

Home Phone:
Work Phone:

If this is not correct, please write your correct address and phone numbers below:

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: (_ _ _) _ _ _ - _ _ _ _

Work Phone Number: (_ _ _) _ _ _ - _ _ _ _

Has your name changed? ☐ No ☐ Yes

If yes, please write your new name: _____

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INFORMATION UPDATE

We try our best to maintain contact with all participants of the Fernald Medical Monitoring Program. In the past, you have given us names of three people who would know how to contact you if we did not have your current address and/or phone number. Would you please review these names and their contact information and make any additions/changes needed at this time?

CONTACT 1 Name:

Address:

Phone:

Relationship: SISTER & BROTHER-IN-LAW

CONTACT 2 Name:

Address:

Phone:

Relationship: BROTHER & SISTER-IN-LAW

CONTACT 3 Name:

Address:

Phone:

Relationship: BROTHER-IN-LAW & SISTER

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Please tell us about medical problems that have occurred since DECEMBER 1, 2005. If you are unsure if a new medical problem, hospitalization, or surgery occurred BEFORE or AFTER DECEMBER 1, 2005, please list it anyway. If you had a medical event since DECEMBER 1, 2005, but have reported it to us previously, please list it again on this form. If you are unsure of any information, please give us your best guess.

TODAY'S DATE: __ / __ / 200__

1. Has your physician diagnosed any new medical problem since DECEMBER 1, 2005?

☐ No
☐ Yes IF YES, could you please give us information about that problem (s)?

New Medical Problem	Month and Year of Diagnosis
_____	_____ (Month) __ __ __ __ (Year)
_____	_____ (Month) __ __ __ __ (Year)
_____	_____ (Month) __ __ __ __ (Year)
_____	_____ (Month) __ __ __ __ (Year)

2. Have you been hospitalized for any reason since DECEMBER 1, 2005?

☐ No
☐ Yes IF YES, could you please give us information about your hospitalization?

Name of hospital: _____

Date of hospitalization: _____

Reason for hospitalization: _____

Physician's name: _____

Hospitalized more than one time in the past year? ____ Yes ____ No

3. Have you had any surgery since DECEMBER 1, 2005? (Please include both surgery in the hospital and surgery as an out-patient).

☐ No
☐ Yes IF YES, could you please give us information about your surgery? If you do not know the exact medical term for your surgery, just describe it as best as you can.

Type of surgery: _____

Date of surgery: _____
month day year

Reason for surgery: _____

Name of hospital or clinic: _____

Physician's name: _____

More than one surgery during the past year? ____ Yes ____ No

4. List any medications that you now take on a regular basis (at least 2 times in a week). Include both prescription and non-prescription medications. Please copy the drug name and other information from the bottle or vial. DOSE is often the number of milligrams or mgs. FREQUENCY refers to "three times per day," or "every 4 hours," or "as needed."

	MEDICATION NAME	DOSE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

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FERNALD MEDICAL MONITORING PROGRAM
2007 QUESTIONNAIRE

TWELVE ITEM HEALTH STATUS QUESTIONNAIRE VERSION 2.0

INSTRUCTIONS:

This survey asks for your views about your health. This information will help the Program keep track of how you feel and how well you are able to do your usual activities.

Answer every question by circling the appropriate number, 1,2,3,.... If you are unsure about how to answer a question, please give the best answer you can and make a comment in the LEFT MARGIN.

1. In general, would you say your health is: (circle one number)

Excellent.....1
Very Good.....2
Good.....3
Fair.....4
Poor.....5

2. The following items are about activities you might do during a typical day. Does YOUR HEALTH now limit you in these activities? If so, how much?

(CIRCLE 1, 2, or 3 ON EACH LINE.)

	Yes, Limited a Lot	Yes, Limited a little	No, Not Limited at All
Lifting or carrying groceries	1	2	3
Climbing SEVERAL flights of stairs	1	2	3
Walking SEVERAL blocks	1	2	3

3. How much BODILY pain have you had during the PAST 4 WEEKS? (circle one number)

None.....1
Very mild.....2
Mild.....3
Moderate.....4
Severe.....5
Very severe.....6

4. These questions are about how you feel and how things have been with you during the PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling.

How much time DURING THE PAST 4 WEEKS..... (circle one number on each line)

	All of the Time	Most of the Time	A Good Bit of the time	Some of the Time	A Little of the Time	None of the Time
Have you felt calm and peaceful?	1	2	3	4	5	6
Did you have a lot of energy?	1	2	3	4	5	6
Have you felt down-hearted and blue?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6

5. During the PAST 4 WEEKS how much difficulty did you have doing your work or other regular daily activities AS A RESULT OF YOUR PHYSICAL HEALTH?

None at all.....1
A little bit.....2
Some.....3 (circle one number)
Quite a bit.....4
Could not do daily work.....5

6. During the PAST 4 WEEKS, to what extent have you accomplished less than you would like in your work or other regular daily activities AS A RESULT OF YOUR EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

Not at all.....1
Slightly.....2
Moderately.....3 (circle one number)
Quite a bit.....4
Extremely.....5

7. During the PAST 4 WEEKS, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all.....1
Slightly.....2
Moderately.....3 (circle one number)
Quite a bit.....4
Extremely.....5

During the LAST year, did you have a chest X-ray which was NOT arranged through the Fernald Medical Monitoring Program?

☐ NO
☐ YES If YES, Where? _____

When? _____, _____
month/day year

Were the results: ☐ Normal
☐ Not Normal
What was the problem? _____

ONLY FOR WOMEN WHO ARE AGE 40 YEARS AND OLDER:

In order to have a complete and up to date medical record for you, we need to know where you had your LAST mammogram. If you had a mammogram that was NOT part of the Fernald Medical Monitoring Program, we do not have that information.

During the LAST year, did you have a mammogram which was NOT arranged through the Fernald Medical Monitoring Program?

☐ NO
☐ YES If YES, Where? _____

When? _____, _____
month/day year

Were the results: ☐ Normal
☐ Not Normal
What was the problem? _____

Are you NOW using a well or cistern as a source of drinking water for your home? (Check all that apply.)

☐ No, neither a cistern or a well.

☐ Yes, using a cistern

☐ Yes, using a well

HEALTH HISTORY INFORMATION

The next section of this form requests information about your health habits. This information is important for your medical record.

1. Do you now smoke cigarettes?

   _____ No

   _____ Yes IF YES, number of cigarettes per day _____

2. Do you now smoke cigars?

   _____ No

   _____ Yes IF YES, number of cigars per week _____

3. Do you now smoke a pipe?

   _____ No

   _____ Yes IF YES, number of pipes of tobacco per week _____

4. Do you now chew tobacco?

   _____ No

   _____ Yes IF YES, average number of times per week _____

5. Do you now dip snuff?

   _____ No

   _____ Yes IF YES, average number of times per week _____

6. How many drinks of alcoholic beverages do you now have in a typical week? PLEASE WRITE IN THE NUMBER OF EACH TYPE OF DRINK :

   ____ Bottles or cans of beer (12 oz)

   ____ Wine coolers (12 oz)

   ____ Glasses of wine (6 oz)

   ____ Mixed drinks or shots of liquor (1.5 oz)

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MENSTRUAL HISTORY QUESTIONNAIRE

1. How old were you when you started having menstrual periods?
   Age: _____ 1a. If you cannot remember your exact age, were you:

   ☐ Younger than 10 ☐ 16 or older
   ☐ 10-12 yrs old ☐ Don't Know
   ☐ 13-15 yrs old

2. At present which statement BEST describes your menstrual cycle?

   ☐ I'm still having regular periods: The date of my last period was: ___/___/_____
   ☐ My periods are irregular: The date of my last period was: ___/___/_____
   ☐ I'm pregnant, or my last pregnancy ended within the past 2 months, or I'm breast feeding

   ☐ My periods have stopped on their own. (I've had menopause.)
   ☐ I've had menopause, but now have periods because I am taking hormones.
   ☐ I've had an operation (surgery) which stopped my periods.
   If your menstrual periods ceased because of surgery, what did you have removed?

   ☐ One ovary only ☐ Uterus only
   ☐ Both ovaries ☐ Uterus and one ovary
   ☐ Uterus and both ovaries
   ☐ Don't know

   ☐ I've taken medication which has stopped my periods.
   If your periods stopped because of medication, which medication were you taking?

   Medication name: _____

   ☐ I've had chemotherapy which has stopped my periods.
   ☐ I've had radiation therapy which has stopped my periods.
   ☐ Other: _____

3. If your menstrual periods have stopped, how old were you when your menstrual periods stopped? (Please provide us with the age at which your menstrual periods stopped regardless of why they have stopped - naturally, due to surgery, medication, chemotherapy, radiation therapy or surgery. If your periods have stopped, but you now have periods because of taking hormones, answer with the age at which your periods first stopped.)

   Were you: ☐ Younger than 20 ☐ 45-49 yrs old
   ☐ 20-29 yrs old ☐ 50-54 yrs old
   ☐ 30-39 yrs old ☐ 55 - 59 yrs old
   ☐ 40-44 yrs old ☐ 60 or older

   OR ☐ My menstrual periods have not stopped.

4. If your menstrual periods have stopped, how old were you when you first experienced symptoms of menopause such as hot flashes or night sweats?

_____ Years old

☐ Did not experience symptoms
☐ Don't Know

OR ☐ My menstrual periods have not stopped.

All women should answer the next two questions, whether they currently have menstrual periods or not.

5. When you are (were) having regular menstrual cycles, how many days are (were) there between periods?

_____ Days between periods

For how many days do (did) you have your period? _____ Days

6. Between the ages of 18 and 40, excluding times when you may have been on the pill, pregnant, or nursing, which of the following statements BEST describes your menstrual periods?

They are (were) ...

☐ Nearly always regular, that is, you could usually predict when you would start bleeding to within two or three days

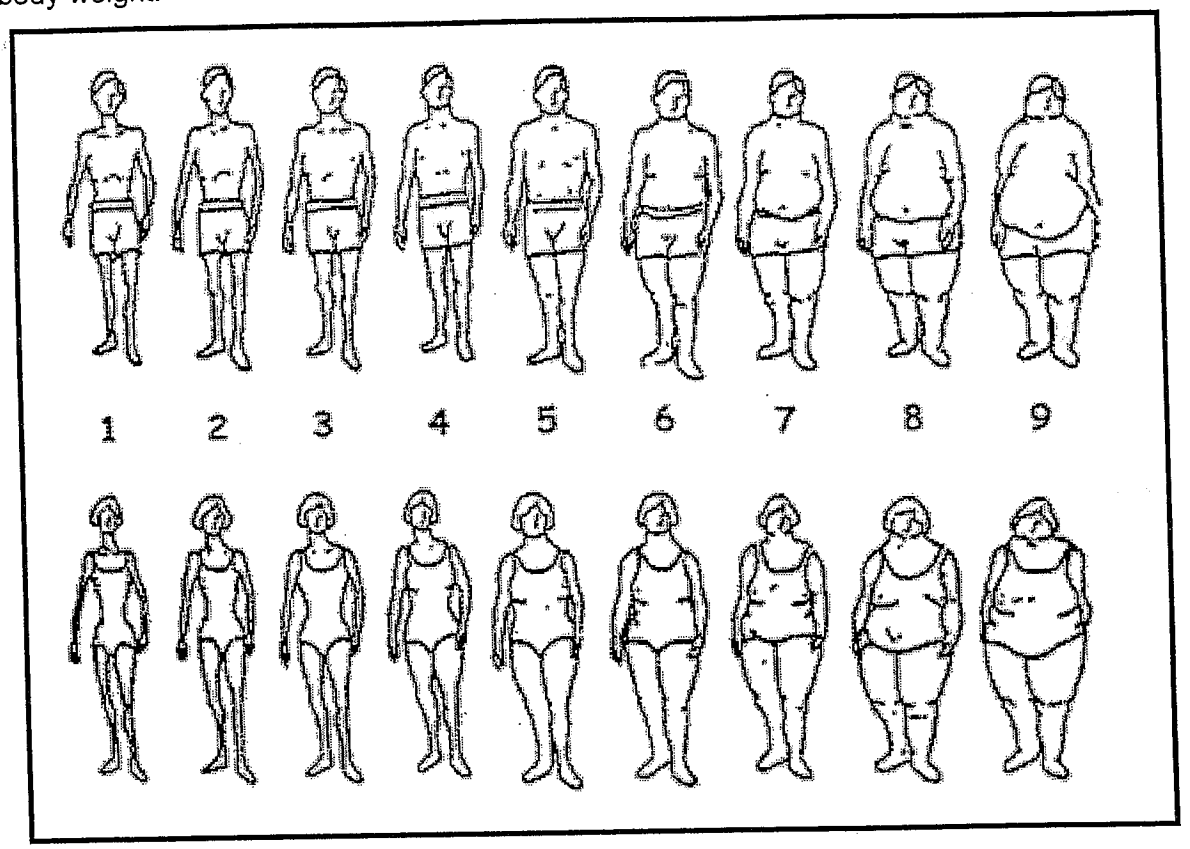
☐ Fairly Regular

☐ Irregular

☐ Don't Know

Body Shape and Size:

This next set of questions is designed to help us better understand your body shape and size, and the body shape and size of your parents. Weight and body size are related to risk of developing many diseases, such as high blood pressure and obesity. Knowing about the body shape and size of your parents can help us to understand your risk of becoming overweight, and your risk of developing conditions that may be related to body weight.



1. Using the diagram above, **which of the body shapes best describes your body shape now? Please circle the correct number.** (If you have recently lost weight because of illness, select the body shape that best describes your usual body shape.)

1 2 3 4 5 6 7 8 9 ☐ **DON'T KNOW**

2. Using the diagram, which of the body shapes best describes **your body shape at age 18?**

1 2 3 4 5 6 7 8 9 ☐ **DON'T KNOW**

3. Which of the body shapes best describes your **biological mother's body shape?** (If your mother recently has lost weight because of illness, or is deceased, select the body shape that best describes her usual body shape before her illness or death.)

1 2 3 4 5 6 7 8 9 ☐ **DON'T KNOW**

Your mother's current age or age at death: ☐☐ ☐ DON'T KNOW ☐ **Mother is deceased**

4. Which of the body shapes best describes your **biological father's body shape?** (If your father recently has lost weight because of illness, or is deceased, select the body shape that best describes her usual body shape before her illness or death.)

1 2 3 4 5 6 7 8 9 ☐ **DON'T KNOW**

Your father's current age or age at death: ☐☐ ☐ DON'T KNOW ☐ **Father is deceased**

5. What is your Pant Size?

Women: Pant Size _____ _____ ☐ DON'T KNOW

☐ Petite ☐ Junior ☐ Misses ☐ Women's

Men: Pant Waist Size _____ _____ ☐ DON'T KNOW

6. How do your pants fit?

- ☐ Waist area fits more tightly than hip area
- ☐ Hip area fits more tightly than waist
- ☐ No difference in fit of waist and hips

Please tell us about the occupations you have had during your lifetime, or the industries in which you have worked. Circle YES or NO for each listed. (You may have had more than one job or occupation at the same time.) If YES, please tell us the total number of years that you worked in that occupation or industry. If you are not certain of the exact number, just give us your best guess.

Occupation or Industry		If Yes, Total Years
Homemaker	YES NO	
Dairy Farming	YES NO	
Animal Farming (pig, chicken, etc)	YES NO	
Vegetable or Crop Farming	YES NO	
Orchard Grower	YES NO	
Gardener	YES NO	
Landscaper	YES NO	
Pesticide Applicator	YES NO	
Crop Duster	YES NO	
Exterminator	YES NO	
Forestry/Logging	YES NO	
Welder	YES NO	
Steel Worker	YES NO	
Foundry Worker	YES NO	
Battery Worker	YES NO	
Ceramic or Pottery Worker	YES NO	
Glass Blower	YES NO	
Miner (Type:)	YES NO	
Insulator	YES NO	
Metal Smelting (Type:)	YES NO	
Coal Plant Worker/ Burner	YES NO	
Aerospace Assembly Line	YES NO	
Auto Body Painter	YES NO	

House Painter	YES NO	Total Years
Commercial Artist	YES NO	
Chemist/Chemical Technician	YES NO	
Biologist/Technician	YES NO	
Chemical Plant Worker	YES NO	
Nuclear Plant Worker	YES NO	
Auto or Truck Mechanic	YES NO	
Railroad Repairman	YES NO	
Fuel Oil Dealer or Worker	YES NO	
Paper or Pulp Mill Worker	YES NO	
Sawmill Worker	YES NO	
Boat Building	YES NO	
Furniture Maker/Finisher	YES NO	
Printer	YES NO	
Engraver	YES NO	
Lithographer	YES NO	
Jewelry Maker	YES NO	
Electroplater	YES NO	
Medical/Scientific Instrument Maker	YES NO	
Brazier or Solderer (Type of metal: _____)	YES NO	
Dentist/Dental Assistant	YES NO	
Doctor	YES NO	
Nurse	YES NO	
Physician's Assistant	YES NO	
Teacher (Type: _____)	YES NO	
Other Occupation (Type: _____)	YES NO	

MEDICAL MONITORING PROGRAM CODE: _____

FEMALE REPRODUCTIVE HISTORY

IN ORDER TO HAVE COMPLETE INFORMATION FOR THIS MEDICAL MONITORING PROGRAM, WE NEED TO KNOW ABOUT YOUR REPRODUCTIVE HEALTH AND ABOUT ANY PREGNANCIES YOU MAY HAVE HAD IN THE PAST.

WHAT IS YOUR DATE OF BIRTH ___ / ___ / 19 ___
MONTH DAY YEAR

TODAY'S DATE ___ / ___ / 19 ___
MONTH DAY YEAR

1. Has there ever been a time period of one year or more when you were trying to be come pregnant, but were unsuccessful?

1. |_| Yes 0. |_| No -----> GO TO QUESTION 2 ON THIS PAGE

A. IF YES, please give the approximate dates for this time period. (If more than one such period of time, check this box |_| and specify the last time)

From: ___ 19 ___ To: ___ 19 ___
MONTH YEAR MONTH YEAR

B. Has a cause or reason for the infertility problem been identified by a physician?

1. |_| Yes 0. |_| No

2. Is your partner employed in a job where he works with chemicals?

1. |_| Yes 0. |_| No 2. |_| NO PARTNER

3. Are you now pregnant?

1. |_| YES - IF YES, "What is your due date?" ___ / ___ / ___
MONTH DAY YEAR

2. |_| no

4. Altogether how many times have you been pregnant, including live births, stillbirths, miscarriages, abortions, tubal pregnancies, and a current pregnancy? (FOR EXAMPLE, 2 pregnancies = 0 2)

PREGNANCIES: ___ ___

IF YOU HAVE EVER BEEN PREGNANT AT ANY TIME AND THAT PREGNANCY HAS ENDED WITH A BIRTH, MISCARRIAGE, ABORTION, STILLBIRTH OR TUBAL PREGNANCY, GO TO THE NEXT PAGE TO COMPLETE THE PREGNANCY HISTORY CHART.