HEALTH HISTORY

ID NUMBER: | | | | | | | |

FORM CODE: | H | H | F |

DATE: 10/04/2017
Version 2.0

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: *Enter the answer given by the participant for each response.*

Script: "Next I will be asking you some questions about your medical history. If you answer that you have been diagnosed with any of these medical conditions, I will then ask you if you have taken medications for these conditions."

	a. Have you **EVER** been told by a doctor or other health professional that you had any of the following conditions?	**b.** Are any of your current activities limited by this condition?	**c.** Do you currently take any prescription medications for this condition?	**d.** Do you currently take any over-the-counter medications for this condition?
Part A: Cardiovascular conditions				
1. **Hypertension**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
2. **Congestive heart failure**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
3. **Angina/chest pain**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
4. **Heart attack/myocardial infarction**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
5. **High cholesterol**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
6. **Diabetes**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
Part B: Cerebrovascular disease				
7. **Stroke**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know

	a. Have you **EVER** been told by a doctor or other health professional that you had any of the following conditions?	**b.** Are any of your current activities limited by this condition?	**c.** Do you currently take any prescription medications for this condition?	**d.** Do you currently take any over-the-counter medications for this condition?
8. **Transient ischemic attack (TIA)**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
Part C: Neurologic or mental health conditions				
9. **Parkinson's disease**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
10. **Dementia or Alzheimer's disease**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
11. **Depression**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
12. **Anxiety**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
Part D: Other conditions				
13. **Osteoporosis**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
14. **Arthritis**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
15. **Asthma**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
16. **Chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
17. **Weak or failing kidneys? Do not include kidney stones, bladder infections, or incontinence.**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
18. **Liver Conditions, for example cirrhosis of the liver, chronic liver disease**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know
19. **HIV/AIDS**	☐ Yes ☐ No -> Next ☐ Don't Know -> Next	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know	☐ Yes ☐ No ☐ Don't Know

Health Behaviors

20. Have you smoked >100 cigarettes (5 packs) in your lifetime?

☐ Y=Yes

☐ N= No → **Go to Item 25**

21. How old were you when you first started regular cigarette smoking?

☐☐ years

22. Do you now smoke cigarettes?

☐ Y=Yes → **Go to Item 24**

☐ N= No

23. How old were you when you stopped smoking?

☐☐ years

24. On the average of the entire time you smoked, how many cigarettes did you usually smoke per day?

☐☐☐ cigarettes

25. Have you ever consumed alcoholic beverages?

☐ Y=Yes

☐ N= No → **Go to Item 29**

26. Do you presently drink alcoholic beverages?

☐ Y=Yes → **Go to Item 28**

☐ N= No

[*If the participant asks, or if the answer is not explicit, "presently" is defined as within the last 6 months.*]

27. Approximately how many years ago did you stop drinking?

☐☐ years

[*Record the response in years, rounding ½ down. For example, "1 ½ years" would be recorded as 1 year. "About a half year ago" would be recorded as "0." If the participant stopped more than once, record the years since the most recent stopping. For example, if the participant says: "The last time I quit was two years ago. The first time I quit was twenty years ago", the response would be recorded as "2".*]

Frequency of alcohol consumption is determined as usual weekly intake. The serving sizes are different for beer, wine and hard liquor. A serving of alcohol is considered to be a "12 oz. bottle or cans of beer," "4 oz. glass of wine" or "1 and ½ oz. shots of hard liquor."

28. How many servings of alcohol do you or did you usually have per week?

☐☐ per week→ **IF 0, Go to Item 29**

28a. How many days in a week do you or did you usually drink alcohol?

☐ days

29. Over the past 2 weeks, have you done any brain games or brain training (e.g. Lumosity, puzzles, etc.) to help your memory or thinking skills?

☐ Y=Yes
☐ N=No → **go to 30**

29a. Over the past 2 weeks, how many hours per day on average have you done brain training?

☐ 1= Less than 1 hour
☐ 2= 1-2 hours
☐ 3= More than 2 hours

30. Are you currently using hearing aids?

☐ Y=Yes
☐ N=No → **End Form**

30a. Which ear?

☐ L= Left
☐ R= Right
☐ B= Both

30b. What year did you begin wearing hearing aids? ☐☐☐☐
Y Y Y Y