# PERSONAL AND MEDICAL HISTORY

SA

ID # _____

# CANADIAN STUDY OF HEALTH AND AGING

## PERSONAL AND MEDICAL HISTORY

---

### Instructions:

Thank you once again for helping us with this questionnaire. The information that you are providing is very valuable to us. Please call _____ at (  )  -  if you have any questions.

Some questions may not apply to you. If that is the case, please check the 'no' or 'never' response and go to the next one.

For many of the questions, we are asking you simply to check the appropriate circle or circles.

Example: Have you ever been a regular coffee drinker?

☒ YES

☐ NO

For office use only: I.D. No. _____

| Letter | Y / N |
|---|---|
| SA | 1 |
| E | 1 |

INT # _____

# CANADIAN STUDY OF HEALTH AND AGING

# PERSONAL AND MEDICAL HISTORY

## BACKGROUND

First, we would like to ask you for some background information and personal history.

1. ***Birthdate***

   Day _____ Month _____ Year ____

2. ***Sex***

   ❒ Male ❒ Female

3. ***Where were you born?***

   ***Province***_____

   ***Country***_____

4. ***If you were not born in Canada, in what year did you come to live in Canada?***

   _____

5. ***What is your current marital status?*** *Please check one category.*

   ❒ Never married

   ❒ Married

   ❒ Common law marriage

   ❒ Separated

   ❒ Divorced

   ❒ Widowed

6. *How many years of elementary and secondary school have you completed?*

Years: _____

***What diplomas, certificates or degrees have you obtained?*** *Mark as many circles as apply to you:*

- ❒ None
- ❒ High school diploma
- ❒ Trade certificate or diploma
- ❒ Other non-university certificate or diploma (e.g. community college, technical schools, nursing schools)
- ❒ University degree (Bachelors, Masters or Doctorate level)

7. ***To which ethnic or cultural groups do you belong? Check as many as apply.***

| | | |
|---|---|---|
| ❒ French | ❒ Italian | ❒ Chinese |
| ❒ English | ❒ Ukrainian | ❒ Japanese |
| ❒ Irish | ❒ Dutch | ❒ Native Peoples |
| ❒ Scottish | ❒ Polish | ❒ Other *Please specify:* |
| ❒ German | ❒ Jewish | _____ |
| | | _____ |
| | | _____ |

## RESIDENTIAL HISTORY

8. *Please tell us where you have lived during your life, starting with your current place of residence, and working backwards.*

| Town or city | County | Province (or country if not in Canada) | From (Year) | To (Year) | Please check applicable sources of drinking water | | | | For office use only |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | City | Well | Other | Don't know | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

## OCCUPATIONAL HISTORY

9. *What occupations have you had since leaving school? For each job, please tell us the job and name or type of the industry you held. If you held the same job for different companies, you may group these companies, for example, job - waiter, industry - restaurant. Please start with your most recent job.*

| Job title | Industry | Duration | | For office use only |
|---|---|---|---|---|
| | | From year | To year | |
| EXAMPLE: Welder | Construction Co. | 1975 | 1978 | |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |

10. *In any of your jobs, were any of the following products used, or were any of these conditions present?*

| Product | Yes | Please indicate job numbers from question 9. | No | Don't know |
|---|---|---|---|---|
| Inks or dyes | | | | |
| Paints, stains, varnishes | | | | |
| Gasoline, fuels, oils | | | | |
| Solvents (degreasers) | | | | |
| Liquid plastics or rubbers | | | | |
| Glues or adhesives | | | | |
| Pesticides, fertilizers | | | | |
| Defoliants, fumigants | | | | |
| Radiation | | | | |
| Excessive noise | | | | |
| Vibratory tools | | | | |
| Other: *Please specify.* | | | | |
| | | | | |
| | | | | |
| | | | | |

10. *In any of your jobs, were any of the following products used, or were any of these conditions present?*

| Product | Yes | Please indicate job numbers from question 9. | No | Don't know |
|---|---|---|---|---|
| Inks or dyes | | | | |
| Paints, stains, varnishes | | | | |
| Gasoline, fuels, oils | | | | |
| Solvents (degreasers) | | | | |
| Liquid plastics or rubbers | | | | |
| Glues or adhesives | | | | |
| Pesticides, fertilizers | | | | |
| Defoliants, fumigants | | | | |
| Radiation | | | | |
| Excessive noise | | | | |
| Vibratory tools | | | | |
| Other: *Please specify.* | | | | |
| | | | | |
| | | | | |
| | | | | |

## HOBBIES AND SPORTS

11. *During your adult life did you spend time on any of the following activities? How frequently? Please check the category corresponding to the time when you most frequently did these activities.*

| Activity | Highest frequency - amount of time | | | |
|---|---|---|---|---|
| | Often (once a week for at least 6 months) | Sometimes (once a month for at least 6 months) | Occasionally (a few times a year) | Rarely or never |
| Gardening | | | | |
| Home or furniture repairs or restoration | | | | |
| Painting (pictures) | | | | |
| Car or motorcycle maintenance | | | | |
| Contact sports (boxing etc) | | | | |
| Camping | | | | |
| Boating | | | | |
| Other hobbies: *please specify:* | | | | |
| | | | | |
| | | | | |
| | | | | |

12. *Did (do) any of your activities listed in question 11 above expose you to any of the following? How frequently? Please check the category corresponding to the time when you most frequently used these substances.*

| Exposure | Highest frequency | | | | |
|---|---|---|---|---|---|
| | Often (once a week for at least 6 months) | Sometimes (once a month for at least 6 months) | Occasionally (a few times a year) | Rarely or never | Don't know |
| Chemical solvents - turpentine | | | | | |
| Paint remover, degreasing agent etc. | | | | | |
| Paints, stains or lacquers | | | | | |
| Aerosol or spray paints | | | | | |
| Film developing fluids | | | | | |
| Dyes | | | | | |
| Pesticides or herbicides | | | | | |
| Plastic cement, glues | | | | | |
| Plastic resins | | | | | |
| Epoxy resins | | | | | |
| Fuels, gasoline or petroleum | | | | | |
| Other (specify) | | | | | |
| | | | | | |
| | | | | | |

## YOUR FAMILY

We would like to know about you and your family.

13. ***In what year was your mother born?***

_____

14. ***In what year was your father born?***

_____

15. ***How many <u>older</u> brothers and sisters do you have? Please include any who have died, even if this happened when they were very young.***

_____ brothers

_____ sisters

16. ***How many <u>younger</u> brothers and sisters do you have? Please include any who have died, even if this happened when they were very young.***

_____ brothers

_____ sisters

17. ***How many children do you have? Please include any who have died, even if this happened when they were very young.***

_____ children

18. ***Are you a twin?***

☐ YES ☐ NO → PLEASE GO TO QUESTION 21.

19. ***Are you the same sex as your twin?***

☐ YES ☐ NO

20. ***Do you consider yourselves to be identical?***

☐ YES ☐ NO

## YOUR HEALTH

21 a) *Have you suffered from any of the following health problems?*

| Health problem or condition | No | Don't know | Yes | How long have you had this condition? |
|---|---|---|---|---|
| Thyroid condition | | | | |
| Stomach Ulcer | | | | |
| Heart attack | | | | |
| Other heart condition | | | | |
| Stroke | | | | |
| Migraine | | | | |
| Kidney condition or disease | | | | |
| Leukemia | | | | |
| Other cancer - specify type or location: | | | | |
| Parkinson's disease | | | | |
| Epilepsy | | | | |
| Diabetes | | | | |
| Multiple sclerosis | | | | |
| Paralysis of any kind | | | | |
| Arthritis or rheumatism | | | | |
| High blood pressure | | | | |
| Learning disability | | | | |
| Depression | | | | |
| Other psychiatric illness | | | | |
| Lou Gehrig's disease (amyotrophic lateral sclerosis) | | | | |
| Other - *specify:* | | | | |
| | | | | |
| | | | | |
| | | | | |

21 b) *Please list all medications you are currently taking for any of the above conditions. Please fill in the names of medications on pill bottles or containers, and include both prescription and non-prescription types, as well as vitamins, minerals and laxatives that you take.*

| Name of medication | How long have you taken this medication? |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

22. ***Have you ever taken antacid preparations regularly (at least once a week for several weeks) in order to relieve an upset stomach?***

YES ❒ NO ❒ → PLEASE GO TO THE NEXT QUESTION.

↓

***Please indicate which kinds of antacids you have taken, how often and for how long. You may complete several of the following categories.***

| **Antacid** | **Taken over approximately how many years?** | **How frequently? (on average)** |
|---|---|---|
| Bromo Seltzer | | |
| Diovol | | |
| Eno | | |
| Epsom salts | | |
| Gelusil | | |
| Maalox | | |
| Mylanta | | |
| Milk of Magnesia | | |
| Pepto Bismol | | |
| Rolaids | | |
| Tums | | |
| Univol | | |
| Other - *Specify:* | | |
| | | |
| Yes, but I don't know which ones | | |

23. *Have you ever taken pain killers (analgesics) regularly (at least once a week for several weeks)?*

YES ❒ NO ❒ → PLEASE GO TO THE NEXT QUESTION.
↓

*Please tell us which ones; for how long and how often?*
*Please include as many as are applicable.*

| **Analgesic (pain killer)** | **Taken over approximately how many years?** | **How frequently? (on average)** |
|---|---|---|
| Aspirin | | |
| Anacin | | |
| Bufferin | | |
| Excedrin | | |
| Tylenol - plain | | |
| Tylenol No: 1, 2, 3 | | |
| 222s, 282s, 292s | | |
| Darvon | | |
| Motrin | | |
| Advil | | |
| Actiprofen | | |
| Indocid | | |
| Other - specify: | | |
| | | |
| Yes, but I don't know which ones | | |

24. *Have you ever used a deodorant or anti-perspirant regularly?*

YES ❒ NO ❒ → PLEASE GO TO THE NEXT QUESTION.
↓

*Please tell us which ones; for how long and how often? Please include as many as are applicable.*

| Deodorant or antiperspirant | Used over how many years? | How frequently? (on average) |
|---|---|---|
| Arrid | | |
| Ban | | |
| Mennen | | |
| Mitchum's | | |
| Old Spice | | |
| Right Guard | | |
| Secret | | |
| Other - *specify:* | | |
| | | |
| | | |

25. *Have you ever had a head injury?*

YES ❒ NO ❒ → PLEASE GO TO QUESTION 29.
↓ PROBABLY NOT ❒ → PLEASE GO TO QUESTION 29.

26. *How many head injuries have you suffered?*

_____

27. *Thinking of the most severe head injury, did you lose consciousness?*

YES ❒ NO ❒ → PLEASE GO TO QUESTION 29.

*For how long were you unconscious?*

❒ A few minutes

❒ Half an hour

❒ Hours - Please tell us approximately how many hours _____

❒ Days - Please tell us approximately how many days _____

❒ Don't know

28. *How old were you at the time? _____ years*
*OR*
*When did this happen*

_____ _____
Month Year

29. *Do you ever get cold sores?*

❒ YES How many per year? _____

❒ NO

30. *Have you had a general anesthetic (been 'put to sleep') for an operation?*

❒ YES ❒ NO → PLEASE GO TO THE NEXT QUESTION.

↓

❒ DON'T KNOW → PLEASE GO TO THE NEXT QUESTION.

***Please give details***

| Year | Type of operation | General anesthesia? | | Did you have difficulty recovering from anesthetic? | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| 19 | | | | | |
| 19 | | | | | |
| 19 | | | | | |
| 19 | | | | | |
| 19 | | | | | |
| 19 | | | | | |

31. *Have you ever received 'shots' (immunization or vaccination) against any of the following diseases?*

❒ NO →PLEASE GO TO THE NEXT QUESTION.

| Type | Approximately how many times? | Approximate year of most recent shot |
|---|---|---|
| Influenza | | |
| Tetanus | | |
| Polio | | |
| Diphtheria | | |
| Other - *specify* | | |
| | | |
| | | |

32. *Have any of your close relatives (parents, brothers and sisters and children) suffered from any of the following conditions?*

| Condition | Relationship of relative(s) to you |
|---|---|
| Alzheimer's disease | |
| Senile dementia | |
| Arteriosclerosis (hardening of arteries) | |
| Mongolism (Down's syndrome) | |
| Mental retardation | |
| Parkinson's disease | |
| Thyroid condition | |
| Leukemia | |
| Depression | |
| Other psychiatric diagnoses | |
| Lou Gehrig's disease (amyotrophic lateral sclerosis) | |
| Other - specify | |
| | |
| | |

## LIFESTYLE

33. ***Have you ever been a regular coffee drinker? (nearly every day)***

❒ YES → for how many years? _____years

❒ NO

34. ***Have you ever been a regular tea drinker? (nearly every day)***

❒ YES → for how many years? _____years

❒ NO

35. ***Have you ever been a regular drinker of soft drinks? (nearly every day)***

❒ YES → for how many years? _____years

❒ NO

36. ***Have you ever smoked cigarettes regularly (nearly every day)?***

❒ YES → for how many years? _____years

On average, how many per day? _____

❒ Less than 1 pack
❒ One pack
❒ More than 1 pack

❒ NO

37. ***Have you ever smoked a pipe regularly (nearly every day)?***

❒ YES → for how many years? _____years

❒ NO

38. ***Have you ever smoked cigars regularly? (nearly every day)***

❒ YES → for how many years? _____years

❒ NO

39. ***Have you ever been a regular beer drinker? (at least once a week)***

❒ YES → for how many years? _____years

❒ NO

↓

40. ***Have you ever been a regular wine drinker? (at least once a week)***

❒ YES → for how many years? _____years

❒ NO

↓

41. ***Have you ever been a regular drinker of spirits? (at least once a week)***

❒ YES → for how many years? _____years

❒ NO

↓

42. ***Have you eaten shellfish (for example, mussels, clams, oysters, scallops, shrimp) regularly? (at least once a month)***

❒ YES → for how many years? _____years

❒ NO

↓

43. ***Have you eaten raw fish regularly? (at least once a month)***

❒ YES → for how many years? _____years

❒ NO

↓

44. ***Have you eaten raw meat regularly? (at least once a month)***

❒ YES → for how many years? _____years

❒ NO

↓

45. ***Have you eaten sausages, liver, kidneys, sweetbreads or other organ meats regularly? (at least once a month)***

❒ YES → for how many years? _____years

❒ NO

↓

46. ***Do you engage in regular exercise?***

❒ YES ❒ NO

↓

How often?

- ❒ Three times a week
- ❒ Once a week
- ❒ Less than weekly

***Type of physical activity***

- ❒ More vigorous than walking
- ❒ Walking
- ❒ Less vigorous than walking

***THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE. PLEASE PUT IT IN THE ENCLOSED ENVELOPE AND RETURN IT TO US.***