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?

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: ______________________

THIS PAGE IS INTENTIONALLY BLANK

FERNALD MEDICAL MONITORING PROGRAM
2007 QUESTIONNAIRE
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:

CONTACT 2 Name:

Address:

Phone:

Relationship:

CONTACT 3 Name:

Address:

Phone:

Relationship:

FERNALD MEDICAL MONITORING PROGRAM
2007 QUESTIONNAIRE
INFORMATION UPDATE

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.			

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

Copyright 1993, 1995 Health Outcomes Institute
All rights reserved.

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)