

THE TREMIN TRUST

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HEALTH REPORT FORM
1987

Please answer all appropriate questions. The questions will require you to think back over the entire year (Jan. 1 - Dec. 31, 1987). You'll note that the questions are xeroxed on front and back. If you need additional space to answer a question feel free to write on an extra sheet of paper, and number the questions to correspond with the question number on this form. Skip questions that do not apply to you. Thank you for your efforts. All answers are confidential.

Background Information

A. Name: I.D. Number:

B. Address: street city state ZIP

C. Phone number: ()

D. [] Please X box if your address changed this year
Date you moved: Old Address:

E. Birth Date: Current Height: Current Weight:

F. Occupation: (please list all jobs you held in 1987 with approximate dates of employment. If you were not working please list that as well):

Table with 2 columns: Job, Dates. Three rows for listing jobs.

G. Current Marital Status
Did your marital status change in 1987? No Yes
If YES, what happened? were you divorced, separated, etc?:

Menstrual Information

- 1. To check our records, would you again indicate your current menstrual status:
I am still menstruating. Go to Question 2.
I think I am in the menopause transition. Go to Question 2.
I am postmenopausal. My last period was on (date). Go to Question 15, page 5.
I am postmenopausal because (please check one):
I had my uterus removed on (date).
I had radiation treatment on (date).
I had chemotherapy treatment on (date).
I went through menopause naturally, (date).

2. Describe your **last period**, did you have **cramps**, if so, how bad were they?, what days during or before your period did they occur?, what was your **bleeding** like (heavy? light? clots, on what days was bleeding light or heavy), any other feelings or symptoms you experienced with that period? Can you recall anything positive about your periods?:

3. Would you say that the period you just described was a typical period for 1987?
 Yes ____ No ____ If NO, why not?

4. Did anything happen to you in 1987 that you think might have affected the normal course of your periods (how regular you are or what your period is usually like), for example, pregnancy, stress, medications, illness, hospitalization? No ____ Yes ____
 If YES, would you please describe the event(s)?

5. Do you use **tampons**? No ____ Yes ____ If yes, what brand? _____

Reason you use this brand? _____
 About how often do you change tampons? _____

Do you use **napkins**? No ____ Yes ____ If yes, what brand? _____

Reason you use this brand? _____
 About how often do you change napkins? _____

6. Did you experience any unusual vaginal bleeding this year, for example, after a birth, abortion, miscarriage or approaching menopause? No ____ Yes ____
 If YES, describe the reasons for this bleeding (if known) and what the experience was like for you (was the bleeding heavy?, did you have any cramps? pass clots? seek help from a care provider? were you concerned?)

7. Were you pregnant in 1987? ____ No, I have not been pregnant.
 ____ Yes, I was pregnant. Please check the outcome of each pregnancy and the date you stopped being pregnant

PREGNANCY OUTCOME

DATE	I'm still pregnant	live birth	still birth	miscarriage	abortion	ectopic pregnancy
#1	_____	_____	_____	_____	_____	_____
#2	_____	_____	_____	_____	_____	_____
#3	_____	_____	_____	_____	_____	_____

8. Did you breast-feed at all in 1987?

No, I have not breast-fed.

Yes, I have breast-fed _____ children. Would you write down how long (months) you breast-fed each child this year?

Child's First Name	Months of Breast-feeding
1 _____	_____
2 _____	_____
3 _____	_____

9. Have you or your partner had problems with infertility in 1987? No , Go to Question 12.
 I haven't been trying to get pregnant. Go to Question 12.

Yes

If YES, Would you briefly describe the difficulties ?

10. Were you or your partner treated or counseled for infertility in 1987? No Yes

If YES, please describe briefly any counseling, medications taken [eg. Clomid] or procedures performed on either you or your partner for infertility and the dates of treatment):

11. Would you share with us anything else that comes to mind about your experience with infertility treatment? What did/do you or your partner think and/or feel about it? Was it effective?

12. Did you use any form of birth control in 1987? No ____ Yes ____
If YES, please check (✓) below **all** the type(s) of birth control used and months of use. Again, think carefully over the whole year.

____ **Oral Contraceptive Pills**, please indicate **all** O.C. pills taken this year:

Brand : _____

Dose : _____ (this is very important so please check)

months used: _____ to _____ (start to stop dates)

Brand : _____

Dose : _____ (this is very important so please check)

months used: _____ to _____ (start to stop dates)

Brand : _____

Dose : _____ (this is very important so please check)

months used: _____ to _____ (start to stop dates)

____ **IUD**, Type _____

months used: _____ to _____ (start to stop dates)

____ **Condom** alone, months used: _____ to _____ (start to stop dates)

____ **Condom with foam or sponge** backup, months used: _____ to _____ (start to stop dates)

____ **Sponge** alone, months used: _____ to _____ (start to stop dates)

____ **Foam/Jellies/Creams** alone, months used: _____ to _____ (start to stop dates)

____ **Diaphragm**, months used: _____ to _____ (start to stop dates)

____ **Cervical Cap**, months used: _____ to _____ (start to stop dates)

____ **Injectable** contraceptive (Depo provera), months used: _____ to _____ (start to stop dates)

____ **Withdrawal**, months used: _____ to _____ (start to stop dates)

____ **Rhythm** (sex only during "safe" days), months used: _____ to _____ (start to stop dates)

____ **Abstinence** (no sex at all), months used: _____ to _____ (start to stop dates)

____ **Others**, _____, months used: _____ to _____ (start to stop dates)

13. Why did you choose the method(s) of birth control you checked above?

14. Take a moment to think about the types of contraception you used during this past year. What did you like or dislike about them?

18. Did you experience **hot flashes** in 1987? No ____ Yes ____
 If YES, describe how they feel: where on your body they start, when they occur (time of day),
 what triggers them, how intense they usually are (mild, moderate, severe), and how long they
 last?

WHERE: _____

WHEN: _____

TRIGGERS: _____

INTENSITY: _____

HOW LONG?: _____

19. Whether or not you are now menopausal, please share with us your thoughts, feelings, fears,
 expectations, of menopause:

Medical Information

20. Did you receive any **radiation** treatment in 1987? No ____ Yes ____
 If YES, please explain why you were treated, dates, how much exposure you
 received, what part of your body was treated, and the specific form of radiation:

21. Did you take any kind of drug that required a **prescription** from a Doctor in 1987 (**except**
 birth control pills, and menopausal estrogens and hormones)? This includes antibiotics,
 antidepressants, pain killers, heart pills, high blood pressure medication, diuretics, other
 hormones, injections, pills, dermal patches, etc. No ____ Yes ____
 If YES, please name the drug you were prescribed, the reason it was prescribed,
 and the dates you took this drug)

Drug Name	Reason Prescribed	Dates Taken
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

22. Did you take any kind of **over-the-counter** drug in 1987? This includes pain killers (aspirin,
 Tylenol), cold medications, diet pills, etc. No ____ Yes ____
 If YES, please name the drug taken, the reason it was taken, the month(s) it was
 taken, and the reason you chose a particular brand

Drug Name	Reason Taken	Month(s) Taken	Reason for that Brand
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

23. Were you or your partner surgically sterilized in 1987? No ____ Yes ____
 If YES, check all surgeries that apply to you or to your partner. If you're not sure about the surgery you had, would you please call your Doctor and find out?
 Thanks!

- ____ Vasectomy, Date: _____
- ____ Tubal ligation (tubes tied), Date: _____
- ____ Oophorectomy (only one ovary)
- ____ Oophorectomy (both ovaries removed, or had a remaining ovary removed), Date: _____
- ____ Hysterectomy (only your uterus removed), Date: _____
- ____ Panhysterectomy (both ovaries and uterus removed), Date: _____

24. Have you had any other kind of surgical procedures, major or minor, including D & C's, in 1987? If so, please specify the type of surgery, the reasons for surgery, and the day and month of the surgery.

Surgery	Reason	Date (Day/Month)

25. Have you been diagnosed as having a chronic illness, for example, diabetes, arthritis, cancer, high blood pressure, heart disease, allergies, dermatitis, lymphoma etc.? No ____ Yes ____
 If YES, indicate the specific chronic illnesses, when diagnosed, severity and frequency of recurrences of illness in 1987.

26. Did you have any major stress in your life during 1987, such as a death of a close family member, marriage, job promotion or loss, illness, car accidents, accidental injuries, or divorce for example? Please think over the entire year...it is easy to forget things that happened early in 1987.
 No ____ Yes ____

If YES, please describe the stress(es) and the date(s) occurred:

27. If you answered YES to question 26, were you hospitalized?
 ____ No.
 ____ No, I was treated in an emergency room and sent home.
 ____ Yes. I was in the hospital from ____ to ____ (dates).

28. Please check (✓) any of the following conditions which you have experienced in 1987:

- | | | | |
|-------------------------------|-------|---------------------|-------|
| Weight Gain | _____ | Dizzy Spells | _____ |
| Cold Flash | _____ | Flooding | _____ |
| Irritability | _____ | Cold Chills | _____ |
| Flooding with Clots | _____ | Depression | _____ |
| Skin Crawls | _____ | Backaches | _____ |
| Forgetfulness | _____ | Urinary Leakage | _____ |
| Cold Hands/Feet | _____ | Excitability | _____ |
| Vaginal Dryness | _____ | Numbness | _____ |
| Can't Concentrate | _____ | Joint Pain | _____ |
| Mood Changes | _____ | Breast Pains | _____ |
| Crying Spells | _____ | Vaginal Infections | _____ |
| Constipation | _____ | Feeling Suffocated | _____ |
| Feeling Fright/Panic | _____ | Periodontal Disease | _____ |
| Diarrhea | _____ | Insomnia | _____ |
| Tiredness | _____ | Heart Pounding | _____ |
| Tingling | _____ | Headaches | _____ |
| Worry about Nervous Breakdown | _____ | | |

29. Did you exercise regularly in 1987? For example, did you run, swim, lift weights, walk, at least **once** a week? No _____ Yes _____

If YES, describe your **normal** weekly exercise routine (what you do, how many times each week you do it, and how many minutes/hours you exercise):

What you do	Times per week	Duration (minutes/hours)

30. Indicate your total family 1987 yearly income category:

- | | |
|--------------------------|-------------------------|
| _____ less than \$10,000 | _____ \$26,000 - 30,000 |
| _____ \$10,000 - 15,000 | _____ \$31,000 - 40,000 |
| _____ \$16,000 - 20,000 | _____ \$41,000 - 50,000 |
| _____ \$21,000 - 25,000 | _____ over \$50,000 |

31. Your current educational level* _____

* for educational level, put highest grade completed, for example: finished high school = 12, or finished college = 16.

32. Are you supporting anyone outside of your household on the income indicated in question 30? No _____ Yes _____

33. Are you the major care giver and/or support person of an older or younger person? (mother, aunt, grandfather, sister, son, other non-relative?) No _____ Yes _____

If YES, please explain:

34. Please answer the following questions using the people who live with you in your household, who are supported by the income you indicated in question 30. A household is where you sleep and eat. If how you live is difficult to fit into this definition, would you please describe your living situation on the back of this page.

People in Your Household

An example is provided.

first name	relationship to you	age	sex	* of months lived in household during 1987	their educational level*	their occupation	hours they worked per week	their app yearly income
Robert	Husband	37	M	12	16	international insurance agent	40	\$37,000

* for educational level, put highest grade completed, for example: finished high school = 12, or finished college = 16.

The purpose of the next 3 questions is to get a smoking **history**. Because smoking is such an important health risk, and because it has not been asked on earlier medical report forms, please answer this question in terms of your **entire** life, not just 1987.

35. Have you ever smoked more than 100 cigarettes in your **entire** life? Yes ____ Go to Question 36
No ____ That's all! You can skip the rest of the questions.
36. Do you smoke now?
____ No. Now many cigarettes did you smoke per day when you did smoke? ____
____ Yes. How many cigarettes do you smoke per day? ____
37. If you smoke now, or have smoked in the past, what was the year you started smoking?
Year started smoking: _____
38. Have you ever quit smoking? No ____ Yes ____
If YES, indicate all the time periods (months or years) that you have quit:

Thank you for taking the time to fill out this Health Report. The information you supply to The Trust is invaluable. We are always trying to improve our questionnaires, so if you have any comments or questions about this new form please write or call. The address and phone number are on the letterhead.