

THE TREMIN TRUST HEALTH REPORT FORM
1995

BACKGROUND INFORMATION

TODAY'S DATE: _____
(mo./day/yr.)

WRITE YOUR ID NUMBER

What is your height without shoes? _____ ft. _____ in. and weight without clothing? _____ lbs.

Did your marital status change in 1995? No _____ Yes _____

If yes, describe previous status: _____ and date of change: _____

HEALTH INFORMATION

1. List below and name ALL chronic illness(es) or chronic condition(s) which you experienced in 1995. For example: allergies, diabetes, cancer, high blood pressure, heart disease, depression, Parkinson's, etc.

___ I DID NOT have any chronic illness(es) or condition(s). → **Skip to Question # 2 below**

___ I DID have the following chronic illness(es) or condition(s). Name the ILLNESS/CONDITION and list all prescribed MEDICATIONS. Indicate the START and STOP MONTHS.

Illness or Condition	Drug Treatment (Name of drug)	Start Month	Stop Month

2. Check below all types of radiation exposure you received in 1995 and the date of exposure.

___ I DID NOT receive any radiation (x-ray) exposure. → **Skip to Question # 3 on next page**

___ I DID receive any radiation (x-ray) exposure.

X-Ray	[V]	Date (Month/Day)

3. List below by name ALL surgical procedure(s) performed on you in 1995, major or minor, including dental surgery, appendectomy, hysterectomy, removal of one or both ovaries (please specify), D & C, tubal ligation, and panhysterectomy (uterus and ovaries removed).

I DID NOT have any surgery performed. → **Skip to Question # 4 below**

I DID have surgery performed. Name the SURGERY, REASON for the surgery, and the DATE of the surgery.

Surgery	Reason	Date (Month/Day)

4. Check [V] any major source of stress during 1995.

I DID NOT experience any major stress. → **Skip to Question # 5 below**

I DID experience a major stress.

Stress	[V]		[V]
Job Loss		Move	
Job-related		Illness	
Divorce		Financial	
Marriage		Illness of Family Member	
Death of Family Member (please specify): _____		Other (Please specify): _____	

5. Check [V] any of the following conditions you experienced in 1995.

Condition	[V]	Condition	[V]	Condition	[V]	Condition	[V]
Weight loss		Tiredness		Breast pains		Flooding (vaginal bleeding in a gush)	
Weight gain		Tingling		Vaginal infections			
Irritability		Dizzy spells		Feeling suffocated		Flooding with clots	
Skin crawls		Cold chills		Periodontal disease		Feeling fright/panic	
Forgetfulness		Depression		Insomnia		Worry about nervous breakdown	
Cold hands/feet		Backaches		Heart pounding			
Vaginal dryness		Urinary leakage		Headaches		Other (Please specify):	
Mood changes		Excitability		Bladder infections			
Crying spells		Numbness		Hot flashes		I experienced none of the above	
Diarrhea		Joint pain		Can't concentrate			

6. Estimate to the best of your ability the number of cigarettes you smoked per day in 1995?

7. Tell us: In your own words, "What does being HEALTHY mean to you"?

PLEASE CHECK THAT YOUR IDENTIFICATION NUMBER IS ON PAGE 1 OF THIS FORM.
Thank you for taking time to fill out the 1995 Health Report. We know that we have asked for a lot of information. As in the past, your comments are encouraged.

Ann M. Voda, R.N., Ph.D.
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