

THE TREMIN TRUST HEALTH REPORT FORM
1997

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 1997? 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 1997. 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 1997 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)

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HEALTH INFORMATION

1. List below and name ALL chronic illness(es) or chronic condition(s) which you experienced in 1997. For example: allergies, diabetes, cancer, high blood pressure, heart disease, depression, Parkinson's, etc.

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

2. Check below all types of radiation exposure you received in 1997 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 1997, 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 (Mcnth/Day)

4. Check [V] any major source of stress during 1997.

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 1997.

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. Indicate below by NAME any sex hormone therapy, for example, estrogen alone(ERT), progesterone alone, or a combination of estrogen and progesterone (HRT), which you took during 1997 for menopause, to regulate bleeding, or for any other reason.

I DID NOT take any hormones during 1997.

I DID TAKE the following medication(s). Indicate below, the HORMONE taken, the DOSE prescribed, the DAYS of the month (1-25) or how many times each week you took the hormone (e.g., 4 days on, 3 days off), and the REASON the hormones were prescribed. Hormone use includes pills, patches and vaginal creams.

Hormone	Dose	Days of month or Days per week taken	Reason for taking

7. If you checked that you DID TAKE hormones in Question #6, did you experience a hormone-induced bleed?

Yes

No

If yes, tell us in your own words, on the back of this form, what your bleeding was like (duration, heavy or light bleeding, cramps, clots, predictability of the bleeding, how you feel about bleeding after menopause).

8. Estimate to the best of your ability the number of cigarettes you smoked per day in 1997?

9. Tell us: In your own words, "What does being HEALTHY mean to you"? Please write your answer on the back of this form.

PLEASE CHECK THAT YOUR IDENTIFICATION NUMBER IS ON PAGE 1 OF THIS FORM AND ON THE CONFIDENTIAL INFORMATION SHEET.

Thank you for taking time to fill out the 1997 Health Report. We know that we have asked for a lot of information. As in the past, your comments are encouraged.

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