

9 Have you ever been told BY A PHYSICIAN that you had any of the following diseases or conditions?

Please also answer whether this disease or condition was treated by a physician.
Please tick the appropriate boxes in each row.

Diseases or conditions:			Were you treated by a physician?	
	No	Yes	Yes	No
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol (blood fats).....	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial infarction (heart attack)	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>
Was an ECG performed?	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>
Blood clot in your leg or lung	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>
If yes, treated with blood thinning drugs?	<input type="checkbox"/>	<input type="checkbox"/>		
Which ones? _____				
Benign breast tumor	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please specify: _____				
Breast cancer.....	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>
Cancer of the uterus/womb	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>
Other type of cancer	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please specify: _____				
Have you had any operations.....	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, please specify: _____				

10 Have one of your parents or any of your siblings died as a result of a myocardial infarction (heart attack) or stroke before the age of 50?

Yes → Who? Mother Father Sibling(s)

No

11 Have one of your parents or any of your siblings ever had a blood clot in the leg or lung?

- Yes → Who? Mother Father Sibling(s)
 No

12 Have your mother or sister(s) ever had breast cancer?

- Yes → Who? Mother Sister(s)
 No

13 Do you regularly use other prescription drugs?

- Yes Please specify _____
 No

14 What is your weight? _____ kg [or pounds]

15 What is your height? _____ cm [or _____ feet _____ inches]

16 Do you regularly smoke cigarettes (at least 1 cigarette per day)?

- Yes → How many cigarettes per day? _____
 No, stopped smoking → How many cigarettes per day did you smoke in the past? _____
 No, never smoked regularly

17 How often do you usually drink alcohol?

- Never Occasionally Regularly (more than 5 drinks a week)

18 How often do you usually engage in physical exercise?

- Never Occasionally Regularly (at least twice a week)

19 How many years of education have you completed, including technical training and university? _____ years

20 Date questionnaire was completed: _____ / _____ / _____ (day/month/year)

THANK YOU! Your TIME AND COMMITMENT ARE MUCH APPRECIATED!