The Methuselah Project HEALTH QUESTIONNAIRE

We Want Your Genes!

Date:

PARTICIPANT NAME		DATE OF BIRTH	GENDER
HEIGHT	WEIGHT	OCCUPATION	
ETHNICITY (please be as specific as possible)			
STREET ADDRESS		MARITAL STATUS	
CITY/STATE/ZIP		PHONE	

FAMILIAL LONGEVITY					
	AGE (when deceased)	**CAUSE**		**AGE (when deceased)**	**CAUSE**
MOTHER			FATHER		
MOM'S MOTHER			DAD'S MOTHER		
MOM'S FATHER			DAD'S FATHER		
SIBLINGS (for each, please indicate sex, current age or age of death if deceased, and cause of death if deceased)					

PHYSICAL ACTIVITY
On average, how often do you exercise (hours/week)?
Do you participate in any organized recreational sporting events? If yes, please list
Overall, how would you rate your state of physical well-being? (on a scale of 1-10: 1 = not healthy, 10 = extremely healthy)

MENTAL ACTIVITY	
Do you play any board games (e.g. checkers, chess)?	How often? (hours/week)
If yes, please list	
Do you play any card games (e.g. bridge, poker)?	How often? (hours/week)
If yes, please list	
Do you do crossword or Sudoku puzzles?	How often? (hours/week)
If yes, please list	
Do you read any books/magazines/newspapers/journals?	How often? (hours/week)
If yes, please list	

MOST SIGNIFICANT HOSPITALIZATIONS/SURGERIES/DIAGNOSTIC TESTS	
HOSPITALIZATIONS/SURGERY/DIAGNOSTIC TEST	**YEAR**

LIST ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS WITH DOSES YOU ARE CURRENTLY USING	
MEDICATION NAME/DOSE	**MEDICATION NAME/DOSE**
Are you allergic to any medications?	
If yes, please list	

THE ROTHBERG INSTITUTE
For childhood diseases
530 Whitfield Street
Guilford, CT 06437
(203)-458-7100 ext. 258

PERSONAL AND FAMILY HISTORY

Please check **Y (YES)** or **N (NO)** to indicate if you now have or ever had any of these problems. If you answer **Y**, indicate **FREQUENCY (NUMBER/YEAR)** and/or **RECENCY (NUMBER OF YEARS AGO)**. If a member of your family has or ever had any of these conditions, please indicate their relationship to you.

<table>
<tr><th rowspan="3">DESCRIPTION</th><th colspan="4">PERSONAL</th><th colspan="2">FAMILY</th><th rowspan="3">ADDITIONAL DETAILS WHERE RELEVANT</th></tr>
<tr><th rowspan="2">YES | NO</th><th rowspan="2">FREQUENCY (#/YR)</th><th colspan="2">RECENCY (# YRS AGO)</th><th rowspan="2">YES | NO</th><th rowspan="2">RELATION (S)</th></tr>
<tr><th>Start</th><th>Last</th></tr>
<tr><td>EAR/NOSE/THROAT</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Hearing difficulty</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Ringing in ears</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Dentures</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>RESPIRATORY</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Asthma</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Emphysema</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Cough up blood</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Short of breath at rest</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Wheezing</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Sleep apnea</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>CARDIOVASCULAR</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Pacemaker</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Heart surgery</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>High blood pressure</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>High cholesterol</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Heart disease</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Chest tightness/pain</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Heart murmur</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Heart palpitations</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Stroke</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Aneurysm</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Blood diseases (e.g. anemia, hemophilia)</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Rapid heart rate at rest</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Swelling in feet/legs</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>ENDOCRINE</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Thyroid problems/disease</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Diabetes</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>GASTROINTESTINAL</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Heartburn/indigestion</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Vomiting blood</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Diarrhea</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Black/bloody stools</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Ulcers/digestive problems</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Gall bladder problems</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Cirrhosis/Liver disease/Hepatitis</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>HEMATOLOGIC/LYMPHATIC</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Bruise easily</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Swollen lymph glands</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>GENITOURINARY</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Painful urination</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Nighttime urination</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Kidney failure/disease</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
<tr><td>Kidney stones</td><td>|</td><td></td><td></td><td></td><td>|</td><td></td><td></td></tr>
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DESCRIPTION	PERSONAL				FAMILY		ADDITIONAL DETAILS WHERE RELEVANT
	YES | NO	FREQUENCY (#/YR)	RECENCY (# YRS AGO)		YES | NO	RELATION (S)	
			Start	Last			
ALLERGIC/IMMUNOLOGICAL							
Nasal allergies	|				|		
Hives	|				|		
Spleen problems	|				|		
Use of prednisone/steroids	|				|		
HIV/AIDS	|				|		
MUSCULOSKELETAL							
Arthritis/gout	|				|		
Osteoporosis	|				|		
Joint pains/swelling	|				|		
Backaches	|				|		
SKIN							
Skin lesions	|				|		
NEUROLOGICAL							
Epilepsy/Seizures	|				|		
Migraines	|				|		
Fainting (syncope)	|				|		
Temporary paralysis	|				|		
PSYCHIATRIC	|				|		
Depression	|				|		
Anxiety	|				|		
Schizophrenia	|				|		
Bipolar disorder	|				|		
WOMEN ONLY							
Breast lumps/tissue changes	|				|		
Hormonal medications	|				|		
MEN ONLY							
Erectile dysfunction	|				|		
CANCER							
Breast	|				|		
Colon	|				|		
Prostate	|				|		
Other (Where?)	|				|		
OTHER							
Drug/alcohol problems	|				|		
OTHER SERIOUS DISEASES/ CONDITIONS							
	|				|		
	|				|		

SOCIAL HISTORY						
INDICATE USAGE	Tobacco	No	Yes	If yes, packs/cans per day?	For how many years?	Date Quit
	Alcoholic Beverages	No	Yes	Drinks per week?	For how many years?	Date Quit
	Caffeinated Beverages	No	Yes	Cups of coffee per day?	Cups of caffeinated soda/tea per day	
CHILDBIRTH HISTORY	# Pregnancies	# Miscarriages/Lost pregnancies			Any pregnancy complications	

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