**CENTRE FOR TRANSLATIONAL PHYSIOLOGY**

University of Otago, Wellington

Tel: 04 8

06 1504



**HEALTH HISTORY QUESTIONNAIRE**

# PLEASE PRINT

1. Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

City: Post Code

Home Phone: Work Phone:

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**☐** Please tick if you would like to be added to our database and made aware of any future research opportunities.

Emergency Contact: Phone:

Relation to you:

1. Employer: Occupation:

1. Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_

Race and/or Ethnic Origin

New Zealand European Maori Pacific Islander

Non New Zealand European Asian Indian

Other

Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 4. GENERAL MEDICAL HISTORY

Do you have any current medical conditions? YES NO If Yes, please explain:

Have you had any major illnesses in the past? YES NO If Yes, please explain:

Have you had any previous exposure to altitude YES NO If Yes, please explain:

(above 2000 m)?

During your previous exposure, did you develop YES NO If Yes, please explain:

any symptoms of acute mountain sickness?

Have you ever been hospitalized or had surgery? YES NO If Yes, please explain: (include date)

and type of surgery, if possible

Are you currently taking any medications or supplements, including aspirin, hormone replacement therapy, or other overthe-counter products?

**Medication/Supplement Reason Times taken per Day Taken for how long?**

Are you allergic to any medications? YES NO If Yes, please explain:

Have you been diagnosed with diabetes? YES NO If Yes, please explain:

# 5. FAMILY HISTORY

Do you have a family history of any of the following: (Blood relatives only, please give age at diagnosis if possible)

## YES NO Relation Age at Diagnosis

## High blood pressure

Heart Attack

Coronary bypass surgery

Stroke

Diabetes

Obesity

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **6. TOBACCO/ALCOHOL/CAFFEINE HISTORY** (check one) |  | **CURRENT TOBACCO USE**  (if applicable) |

# None # per day

Quit (when)

Cigarette Cigarette

Cigar Cigar

Pipe Pipe

Chew Tobacco Chew Tobacco

Nicotine patches Nicotine patches

Total years of tobacco use

Brand of cigarette (including filter or nonfilter)

How much of cigarette smoked (cm butt length)

Inhale versus non-inhaled

Do you consume alcohol? Drinks per day \_\_\_\_ Drinks per week \_\_\_\_

How many beverages containing caffeine to you consume daily? \_\_coffee \_\_tea \_\_ soda \_\_ other

# 7. CARDIOVASCULAR/NEUROLOGICAL/METABOLIC HISTORY

## YES NO

Are you presently diagnosed with heart disease?

Do you have any history of heart disease?

Do you have a heart murmur?

Occasional chest pain or pressure?

Chest pain or pressure on exertion?

High blood pressure?

Do you have any history of stroke or TIA?

Episodes of fainting?

Episodes of dizzyness?

Have you ever had a seizure?

Daily coughing?

Do you get frequent headaches or migraines?

Have you had a head injury?

Are you still experiencing symptoms?

Shortness of breath?

At rest?

Lying down?

After 2 flights of stairs?

Do you have asthma?

Do you have a history of bleeding disorders?

Do you have a history of anaemia?

Do you have a history of problems with blood clotting?

|  |  |  |
| --- | --- | --- |
| **8. (Women only) OBSTETRIC/GYNECOLOGICAL HISTORY** |  |  |
|  | **YES** | **NO N/A** |

Have you completed menopause?

Do you have a normal menstrual cycle (1 menses each ~1 month)?

If yes, please estimate the days since your last period If no, please indicate frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any kind of contraceptive (oral, injectable, implant)?

If yes, please indicate type and name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 9. PHYSCIAL ACTIVITY HISTORY

How many hours a week do you exercise?­­­

How intense is this exercise? LIGHT MODERATE HEAVY

# 10. GENERAL PRACTITIONER

Name:

Address:

Phone:

***Should it be necessary, may we send a copy of your results to your physician?*** YES NO

Reviewed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments: