**General Health Questionnaire for Donors for**

**Verification of Reference Range Study**

ALL INFORMATION IS STRICTLY CONFIDENTIAL AND IS FOR USE WHEN DIAGNOSING ILLNESS AMONG MEMBERS OF YOUR COMMUNITY.

Subject ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sample ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: (M) (F) Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | Do you feel well and consider yourself healthy? | Y | N |
|  | Do you exercise regularly?  If yes, how often? (hours per week)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  And degree of activity (light) 1 2 3 4 5 6 7 8 9 10 (vigorous) | Y | N |
|  | Have you been sick recently?  If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Are you taking any prescribed medication?  If yes, what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Do you have high blood pressure? | Y | N |
|  | Do you take vitamin supplements or herbal remedies?  If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Are you exposed to any hazardous chemicals in your job?  If yes, what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Do you use tobacco?  If yes, what form? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Do you eat a special diet?  If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Do you drink alcoholic beverages?  If yes, what form? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Are you currently under a doctor’s care?  If yes, why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Are there inherited disorders in your family?  If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Have you taken any aspirin or any pain relievers recently?  If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Have you taken any cold or allergy medicine recently?  If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Have you taken any antacids or stomach medicine recently?  If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Are you taking diet pills? | Y | N |
| FOR WOMEN: | | | |
|  | Are you still menstruating?  If yes, first day of your last period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If no, are you on hormone replacement therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Are you breast-feeding? | Y | N |
|  | Are you pregnant?  If yes, what is your due date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Y | N |
|  | Are you on oral or implant contraceptives? | Y | N |

Your signature below means that you voluntarily agree to participate in this research study.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature Date