Know Your Number® Multiple Disease Risk Questionnaire

Your Name:	Today's Date:
Name of Your Physician:	Participant ID #:

PERSONAL INFORMATION					
Date of Birth: / / (MM/DD/YYYY)			Gender:	Male ☐	Female ☐
Ethnic Group: White ☐	African-American ☐	Asian ☐	Hispanic ☐	Native American ☐	Other ☐

PERSONAL HEALTH			
Have you ever been told by a doctor that you have any of the following:		**Yes**	**No**
Diabetes (gestational diabetes not included)		☐	☐
Coronary Heart Disease (angina, heart attack, angioplasty or by-pass surgery)		☐	☐
Stroke/TIA (mini strokes)		☐	☐
Congestive Heart Failure:		☐	☐
Valve Disease or Heart Murmurs		☐	☐
Other Cardiovascular Disease (atherosclerosis, peripheral arterial disease or aortic aneurysm)		☐	☐
Left Ventricular Hypertrophy (enlargement of the left ventricle of the heart)	**Not Evaluated** ☐	☐	☐
Atrial Fibrillation	**Not Evaluated** ☐	☐	☐

FAMILY HISTORY			
Have any of these blood relatives, living or deceased, ever been told by their doctor that they have the following:		**Yes**	**No**
Diabetes	Mother, Father, Sister or Brother	☐	☐
Coronary Heart Disease	Father or Brother (Before age 55) Mother or Sister (Before age 65)	☐	☐
Stroke/TIA	Mother, Father, Sister or Brother	☐	☐

LIFESTYLE			
		Yes	**No**
Do you currently smoke cigarettes		☐	☐
Have you ever regularly smoked cigarettes		☐	☐
Average times per week you exercise for at least 20 minutes	1 or less ☐	2 – 4 ☐	5 or more ☐
While exercising, how hard are you breathing	Normal ☐	Moderate ☐	Hard ☐

MEDICATIONS		
Do you currently take any of the following:	**Yes**	**No**
Medication to lower your blood pressure	☐	☐
Medication to lower your cholesterol	☐	☐
At least one quarter of an adult aspirin (81 mg) daily	☐	☐

FOR WOMEN ONLY		
	Yes	**No**
Are you currently pregnant	☐	☐
How many live births have you had	________	
Were you ever told by your doctor that you had gestational diabetes while pregnant	☐	☐
If yes, how many years since you were last diagnosed	________	
Have you passed through menopause (either naturally or have had your ovaries removed)	☐	☐
Are you currently using any form of hormone replacement therapy (after menopause only)	☐	☐

FOR INDIVIDUALS WHO CURRENTLY SMOKE CIGARETTES		
	Yes	**No**
Has your birth mother or father, living or deceased, ever been told by their doctor that they have lung cancer	☐	☐
Have you ever been told by a doctor that you have any of the following:		
Lung cancer or COPD	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Do you currently have asthma	☐	☐
What is the combined number of years you have smoked	________	
On average, how many cigarettes do you smoke daily	________	

(office use only) CLINICAL INFORMATION		REQUIRED LAB VALUES		OPTIONAL LAB VALUES	
Height	FEET INCHES	Fasting Status	Fasting ☐ Non-Fasting ☐ Unknown ☐	LDL	
Weight	LBS	Fasting Glucose	mg/dL	HbA1C	%
Waist Measurement	INCHES	Total Cholesterol	mg/dL		
Pulse Rate	BPM	Triglycerides	mg/dL		
Blood Pressure	/ (SYSTOLIC /DIASTOLIC)	HDL Cholesterol	mg/dL		