

# Health Questionnaire

Complete the following questions by circling the numbers and give details if appropriate.

STUDENT ID# \_\_\_\_\_ NAME \_\_\_\_\_ **Male/ Female**

■ Please write your student ID number and your name also on the back of the sheet.

**Q1. Have you ever suffered from any illness/disease in the past?**      ① Yes      ② No

At what age?	Name of Illness/Disease	Present Condition

**Q2. Have you ever been detected any abnormality or heart problems on an electrocardiogram?**

③ Yes      ④ No

At what age?	Name of Illness/Disease	Present Condition

**Q3. Are you currently under any treatment or medication?**      ⑤ Yes      ⑥ No

Since when?	Name of Illness/Disease	Type of Treatment/Medication

**Q4. Do you smoke cigarette?**      ⑦ Yes      ⑧ No      ⑨ Quit

*For those who answered ⑦ and ⑨:*

1) Numbers of cigarettes per day    ⑩ Less than 5    ⑪ 5~10    ⑫ 10~20    ⑬ More than 20

2) At what age did you start smoking?      ⑭ \_\_\_\_\_

3) At what age did you quit smoking?      ⑮ \_\_\_\_\_

**Q5. How often do you consume alcohol?**

⑯ Everyday      ⑰ More than 3 days a week      ⑱ Occasionally      ⑲ Never drink

**Q6. Do you have any concerns or worries about your health? Do you want to consult a doctor?**

⑳ Yes(ASAP)      ㉑ Yes(soon or later)      ㉒ No

※ **Questions for female students.**

Q1. Cycle and duration of period is:      ① Stable      ② Sometimes unstable      ③ Unstable

Q2. Do you have severe pain with your period?      ④ Yes      ⑤ Sometimes      ⑥ No

*For those who answered ④ and ⑤:* Do you need medication to relieve the pain?

⑦ Yes, every time      ⑧ Sometimes      ⑨ No

Q3. Do you see a doctor to treat concerns with your period?

⑩ Yes      ⑪ Consider to do so      ⑫ No