

## Life Expectancy Questionnaire

### 1-5. Demographic

- 1a. Last Name \_\_\_\_\_ 1b. First Name \_\_\_\_\_ 1c. MI \_\_\_\_\_
- 2a. Address \_\_\_\_\_ 2b. City \_\_\_\_\_
- 2c. State \_\_\_\_\_ 2d. Zip Code \_\_\_\_\_
3. Sex \_\_\_\_\_ 4. DOB (mm/dd/yyyy) \_\_\_\_\_ 5a. SSN \_\_\_\_\_
- 5b. Annual Family Income \_\_\_\_\_ 5c. Effective Date of Report \_\_\_\_\_

### 6. Smoking

- 6a. Do you currently use any kind of tobacco?  Yes  No
- 6b. If yes, which type do you use most often? \_\_\_\_\_
- 6c. On average over the last 5 years, have you smoked? \_\_\_\_\_
- More than 2 cigarettes/day  More than 2 cigars/day  More than 2 bowl pipes/day

### 7. Build

- 7a. What is your height? \_\_\_\_\_ 7b. What is your weight? \_\_\_\_\_
- 7c. Have you lost more than 10 pounds in the last year?  Yes  No

### 8. Coronary

Have you ever:

- 8a. Had a heart attack?  Yes  No 8b. Had coronary artery bypass surgery?  Yes  No
- 8c. Had angioplasty or stenting of one of your coronary arteries?  Yes  No
- 8d. Been diagnosed with coronary artery disease?  Yes  No
- 8e. Been diagnosed with left ventricular hypertrophy?  Yes  No
- 8f. Been diagnosed with congestive heart failure or cardio myopathy?  Yes  No

### 9. Cerebral

Have you ever:

- 9a. Had a stroke?  Yes  No 9b. Had a Transient Ischemic Attack (TIA)?  Yes  No

9c. Had a carotid endarterectomy?  Yes  No    9d. Had a carotid artery disease?  Yes  No

## 10-11. Peripheral & Aortic

Have you ever:

10a. Been diagnosed with Peripheral Vascular Disease?  Yes  No

10b. Had one of the arteries in your legs stented or bypassed?  Yes  No

11. Have you ever been told that you have an aortic aneurysm?  Yes  No

## 12. Heart Valves

12a. Have you ever had a heart valve repaired or replaced?  Yes  No

12b. Have you ever been diagnosed with:

Aortic insufficiency or regurgitation     Aortic stenosis

Mitral valve insufficiency or regurgitation     Mitral valve stenosis

## 13-18. Fibrillation/Defibrillator/COPD/Diabetes/ Alzheimer's

13a. Have you ever been diagnosed with Atrial Fibrillation?  Yes  No

13b. If yes, are you taking Coumadin or other blood thinners?  Yes  No

14. Do you have a cardiac pacemaker and/or defibrillator?  Yes  No

15. Have you been diagnosed with Chronic Obstructive Pulmonary Disease, Chronic Bronchitis, and/or Emphysema?  
 Yes  No

16a. Have you ever been diagnosed with Sleep Apnea?  Yes  No

16b. If yes, are you using a CPAP or BiPap device at night?  Yes  No

17. Have you been diagnosed with Diabetes or elevated blood glucose?  Yes  No

18a. Have you been diagnosed with Alzheimer's disease and/or Dementia?  Yes  No

18b. Do you reside in a nursing home or assisted living facility?  Yes  No

## 19-21. Fibrillation/Defibrillator/COPD/Diabetes/ Alzheimer's

19. Does anyone help you with:

Getting dressed?     Bathing?     Going to the bathroom?     Eating?

Paying bills or writing checks?     Getting out of bed?

20. Do you use a wheelchair?  Yes  No

21. Have you even been diagnosed with Parkinson's disease?  Yes  No

## 22-26. Cancer

22a. Have you ever been diagnosed with Prostate Cancer?  Yes  No

22b. If yes, how many years ago were you diagnosed? \_\_\_\_\_

23a. Have you been diagnosed with Breast Cancer?  Yes  No

22b. If yes, how long ago were you diagnosed? \_\_\_\_\_ 23c. Were you treated?  Yes  No

23d. Do you currently have any evidence of Breast Cancer?  Yes  No

24. Have you been diagnosed with Lymphoma, Hodgkin's Disease or Leukemia?  Yes  No

25a. Have you ever been diagnosed with Lung Cancer?  Yes  No

25b. If yes, how long ago were you diagnosed? \_\_\_\_\_ 25c. Were you treated?  Yes  No

25d. Do you currently have any evidence of lung cancer?  Yes  No

26a. Have you been diagnosed with cancer other than Prostate Cancer, Breast Cancer, Lymphoma, Hodgkin's Disease,

Leukemia, or Lung Cancer?  Yes  No

26b. If yes, please indicate which type of cancer:

Colon  Melanoma  Ovarian  Esophageal  Bone

Brain  Pancreatic  Other \_\_\_\_\_

26c. How long ago were you diagnosed? \_\_\_\_\_ 26d. Were you treated?  Yes  No

26e. Do you currently have evidence of cancer?  Yes  No

## 27-29. HIV/Hepatitis/Renal

27. Are you HIV positive or have you been diagnosed with AIDS?  Yes  No

28. Do you have Hepatitis C or Hepatitis B?  Yes, Hep C  Yes, Hep B  No

29. Do you have renal insufficiency or other kidney disease?  Yes  No