General Health Questionnaire

Instructions: Please answer the following questions

Health History/Current Conditions: Has a doctor or other healthcare professional ever told you that you have/had any of the following conditions

1. **A heart attack**
   - Yes
   - No
   - Prefer not to say
2. **Other heart issues**
   (Examples: pacemaker, heart valve disease, open heart surgery)
   - Yes
   - No
   - Prefer not to say
3. **Stroke**
   - Yes
   - No
   - Prefer not to say
4. **Circulation problems**
   (Examples: arteriosclerosis, atherosclerosis, blood clots in lungs or leg veins)
   - Yes
   - No
   - Prefer not to say
5. **High Blood Cholesterol**
   - Yes
   - No
   - Prefer not to say
6. **High Blood Pressure**
   - Yes
   - No
   - Prefer not to say
7. **Low Blood Pressure**
   - Yes
   - No
   - Prefer not to say
8. **Parkinson's Disease**
   - Yes
   - No
   - Prefer not to say
9. **Dementia**
   (Examples: Alzheimer's Disease, vascular dementia, etc)
   - Yes
   - No
   - Prefer not to say

10. **If yes, please choose between:**
    - Alzheimer's disease
    - Other
    - Unsure from the options listed
    - Prefer not to say

11. **Mild cognitive impairment**
    (known as "MCI"; mild but noticeable cognitive changes, may slow or interfere with daily activities but does not stop them)
    - Yes
    - No
    - Prefer not to say
12. **Multiple Sclerosis**
    - Yes
    - No
    - Prefer not to say
13. **Other Neurological conditions**
    - Yes
    - No
    - Prefer not to say

14. **Arthritis (joint pain)**
    - Yes
    - No
    - Prefer not to say
15. **Osteoporosis**
    - Yes
    - No
    - Prefer not to say
16. **Cancer (any type)**
    - Yes
    - No
    - Prefer not to say

17. **Chronic pulmonary (lung) problems**
    (Examples: emphysema, asthma, tuberculosis, asbestosis)
    - Yes
    - No
    - Prefer not to say
18. **Digestive problems**
    (Examples: stomach ulcer, gastrointestinal problems, hiatal hernia)
    - Yes
    - No
    - Prefer not to say
19. **Urinary problems**
    (Examples: urinary tract infections, incontinence, prostate problems)
    - Yes
    - No
    - Prefer not to say
20. **Kidney problems**
    - Yes

- No
- Prefer not to say

21. Hearing impairment
- Yes
- No
- Prefer not to say

22. Obesity
- Yes
- No
- Prefer not to say

Type II Diabetes - Additional Information

23. Were either of your parents diagnosed with Type II Diabetes?
- Yes
- No
- Unknown
- Prefer not to say

24. If yes, which parent?
- Mother
- Father

25. Has a sibling been diagnosed with Type II Diabetes?
- Yes
- No
- Unknown
- Prefer not to say

26. If yes, please check all that apply:
- Sister
- Brother
- Half-Sister
- Half-Brother

Eye-Related Health Conditions

27. Glaucoma (in one or both eyes)
- Yes
- No
- Prefer not to say

28. Age-related Macular Degeneration (AMD) (in one or both eyes)
- Yes
- No
- Prefer not to say

29. Cataracts (in one or both eyes)
- Yes
- No
- Prefer not to say

30. Diabetic Retinopathy (in one or both eyes)
- Yes
- No
- Prefer not to say

31. Retinal Vascular Occlusion ("stroke in the eye or eye vessels" - in one or both eyes)

- Yes
- No
- Prefer not to say

32. **Dry Eye (in one or both eyes)**
    - Yes
    - No
    - Prefer not to say
33. **Have you been diagnosed with any conditions not listed above? (any condition, not just eyes)**
    - Yes
    - No
    - Prefer not to say

    If yes, please specify:

    _____

34. **Have you fallen in the last 12 months?**
    (a fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level)
    - Yes
    - No
    - Prefer not to say

    If so, how many times in the last 12 months?

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