Coriell Cell Repositories

NIA Aging Cell Repository Longevity Project
Brief Medical History Report

Date: ______________________________

Age: __________________ Year of Birth: _______ Gender: ____________________________________

Race: Caucasian, Black or African American, Asian, Other ______________ (Circle all that apply)

Ethnicity: Hispanic or Non-Hispanic (Circle one) ____

Indicate ethnic origin of parents and grandparents: ____

____

Family History: Please check box for yes and indicate relation (Father, mother, sisters & brothers) and age of onset if known.

- ☐ arthritis ________________________
- ☐ diabetes ________________________
- ☐ heart disease ________________________
- ☐ hypertension ________________________
- ☐ high cholesterol ________________________
- ☐ obesity ___________
- ☐ cancer ____ (include location of cancer if possible)
- ☐ Alzheimer disease ______________________________
- ☐ None of the above
- ☐ Macular Degeneration ___________

Other (include familial genetic diseases): ____

Have any blood relatives lived to over 90 years of age:__ If yes, relationship __________________________________

Personal Medical History: Please check box for yes and specify type or details and age of onset if known

☐ **Cancer** (location)

____

Heart Disease

- ☐ High blood pressure
- ☐ Coronary artery disease
- ☐ Heart Attack
- ☐ Valvular Disease
- ☐ Atherosclerosis
- ☐ Heart Failure ☐ Other_____

Blood disorders

- ☐ Anemia
- ☐ Polycythemia
- ☐ Multiple Myeloma
- ☐ Other_____________________

Lung Disease

- ☐ Emphysema ☐ Asthma
- ☐ Shortness of breath
- ☐ Other_____________________

Gastrointestinal Disorder

- ☐ Gastroesophageal Reflux Disease
- ☐ Gastritis
- ☐ Ulcers ☐ Polyps
- ☐ Other_____________________

Genitourinary Disorder

- ☐ Benign Prostate Hypertrophy
- ☐ Cysts ☐ Hysterectomy
- ☐ Kidney/bladder stones
- ☐ Urinary Frequency
- ☐ Other_____________________

Joint Disease

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis ______________
- ☐ Degenerative joint disease
- ☐ Other_____________________

Neurological & Psychiatric Disorders

- ☐ Alzheimer Disease
- ☐ Depression ☐ Anxiety
- ☐ Parkinson Disease
- ☐ Stroke __________________
- ☐ Memory Loss
- ☐ Hearing loss
- ☐ Insomnia
- ☐ Other_____________

Eye Disease

- ☐ Cataracts ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other____________________

General Health

- ☐ Diabetes Type_______________
- ☐ Frailty
- ☐ High cholesterol
- ☐ Overweight
- ☐ Severe weight loss? _______
- ☐ Smoker: ___ Never? __Ever? How many years? ______
- ☐ Alcohol Use: __ Daily, __ Weekly, __ less often
- ☐ If you have none of the listed conditions please check this box

Additional remarks: ____

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What medications are you currently taking? ____

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Person collecting history: ____