

Health checkup questionnaire

Last Name		Resident Reg. No..			
Given Name				Mobile phone	
Current address				E-mail	
				How to receive a health checkup report	<input type="checkbox"/> Post <input type="checkbox"/> E-mail

※ Please answer all the questions below.



Medical history (disease history, family history)

1. Have you ever been diagnosed by a doctor with any of the following diseases or are you currently taking any medication?

	Diagnosis		Medication therapy	
	Yes	No	Yes	No
Brain stroke (paralysis)				
Cardiac infarction/angina				
High blood pressure				
Diabetes				
Dyslipidemia				
Tuberculosis				
Others (including cancer)				

2. Has anyone in your family died from or gotten any of the following diseases?

Brain stroke (paralysis)	Yes	No
Cardiac infarction/angina	Yes	No
High blood pressure	Yes	No
Diabetes	Yes	No
Others (including cancer)	Yes	No

3. Are you a Hepatitis B virus antigen carrier?
 ① Yes ② No ③ No idea



Smoking and e-cigarettes (vaping)

4. Have you ever smoked more than 5 packs of cigarettes (100 cigarettes) in your lifetime?
 ① No. (→ Go to Question 5)
 ② Yes. (→ Go to Question 4-1)

4-1. Do you smoke cigarettes now?

① I do	A total of _____ years	An average of _____ cigarettes a day	
② I used to but not anymore	A total of _____ years	Used to smoke _____ cigarettes a day on average	_____ years since I quit

5. Have you ever smoked an electronic cigarette (e.g., IQOS, Glo, or Lil)?
 ① No. (→ Go to Question 6)
 ② Yes. (→ Go to Question 5-1)

5-1. Do you smoke electronic cigarettes now?

① I do	A total of _____ years	An average of _____ cigarettes a day	
② I used to but not anymore	A total of _____ years	Used to smoke _____ cigarettes a day on average	_____ years since I quit

6. Have you ever used a liquid electronic cigarette?

- ① No.
 ② Yes. (→ Go to Question 6-1)

6-1. Have you used a liquid electronic cigarette in the last month?

- ① No ② 1 to 2 days per month ③ 3 to 9 days per month
 ④ 10 to 29 days per month ⑤ Every day



Drinking

※ In the past one year

7. How often do you have drinks containing alcohol? (Select one)
 ① () times per week ② () times per month
 ③ () times per year
 ④ I don't drink alcohol.

- 7-1. How many drinks containing alcohol do you have on a typical day when you are drinking?

* Choose one among the glass, bottle, can, or cc (you can choose more than one for liquor types; choose a similar type for other liquor types that are not indicated)

Type of liquor	Glass	Bottle	Can	cc
Soju				
Beer				
Hard liquor				
Makgeolli (rice wine)				
Wine				

- 7-2. What is the largest amount of drinks containing alcohol that you have ever had in one day?

* Choose one among the glass, bottle, can, or cc (you can choose more than one for liquor types; choose a similar type for other liquor types that are not indicated)

Type of liquor	Glass	Bottle	Can	cc
Soju				
Beer				
Hard liquor				
Makgeolli (rice wine)				
Wine				



Exercising

- 8-1. How often do you do high intensity exercise (making you short of breath) per week?

() days per week

* Examples of high intensity exercise> Running, aerobics, fast bicycling, construction labor, carrying items using stairs, etc.

- 8-2. How long do you do high intensity exercise (making you short of breath) per day?

() hours () minutes per day

- 9-1. How often do you do moderate intensity exercise (making you slightly short of breath) per week?

() days per week

* Exclude exercise you have already written in Question 8

* Examples of moderate intensity exercise> Power walking, doubles tennis games, cycling at normal speed, carrying light items, cleaning, etc.

- 9-2. How long do you do moderate intensity exercise (making you slightly short of breath) per day?

() hours () minutes per day

10. How many days did you do weight training such as push-ups, sit-ups, dumbbell exercises, weight lifting, or horizontal bar exercise in the last one week?

() days per week