## Questionnaire

ID	Date / /				
Name					
Why are you visiting our hospital?  □ Having any symptoms □ Referral from another hospital/clinic □ Abnormal findings on the screening test □ Regular check up					
	ase check all that apply and describe in detail below.  theats □Shortness of breath □Swollen legs □ Leg pain  )				
Are you currently taking any n	nedication?				
□ No □ If yes, please list:	:				
Are you allergic to any medicat  □ No □ If yes, please list:					
Do you smoke?  □ Never □I quit(from age □ Yes, currently ( cigar	~to age cigarettes/day) rettes/day, for years)				
	s a week. ? The amount of alcohol				
	ver had any of the following deseases?				
	e(Angina, Arrhythmia )				
Have you ever had any operation	ons before?				
Type of operation / reasons for operation	( years old) ( years old)				
Please check all that apply and	rs who had any of the following diseases? indicate the relationship to you in the bracket.				
<ul><li>☐ Heart disease (</li><li>☐ Stroke (</li></ul>	)				

f \* There are extra questions on the reverse side if you are over 75 years old.

## Please answer the questions bellow

1	Has your body weight decreased about $4.5 \sim 6.5$ pounds $(2 \sim 3 \text{kg})$ within the last 6 months?	( Yes	/	No )
2	Do you feel your walking speed is slower than before?	(Yes	/	No )
3	Do you exsercise like walking more than once a week?	(Yes	/	No )
4	Could you remember the event what you did 5 minutes ago?	(Yes	/	No )
5	Have you felt tired without obvious reason within the last 2 weeks?	( Yes	/	No )