

X-ray Technicians – Second survey

Personal Non-cancer medical history

33. Have you had any of the following conditions or procedures listed below diagnosed by a physician?

No GO TO NEXT QUESTION

Yes → Please mark “YES” for each condition you’ve had diagnosed by a physician and indicate the time period when you were first diagnosed with that condition.

<u>MEDICAL CONDITION</u>	Mark here for “Yes” ↓	<u>YEAR OF FIRST DIAGNOSIS</u>			
		<u><1980</u>	<u>1980-1984</u>	<u>1985-1989</u>	<u>1990+</u>
Angina Pectoris	<input type="radio"/> →	0	0	0	0
Asthma	<input type="radio"/> →	0	0	0	0
Arthritis, Rheumatoid.....	<input type="radio"/> →	0	0	0	0
Arthritis, Other	<input type="radio"/> →	0	0	0	0
Breast Disease (Fibrocystic or Other Benign)	<input type="radio"/> →	0	0	0	0
Breast Implant, Silicone.....	<input type="radio"/> →	0	0	0	0
Bronchitis, Chronic	<input type="radio"/> →	0	0	0	0
Cataracts	<input type="radio"/> →	0	0	0	0
Cataract Extraction.....	<input type="radio"/> →	0	0	0	0
Cholecystectomy	<input type="radio"/> →	0	0	0	0
Cholesterol, Elevated (240 or greater)	<input type="radio"/> →	0	0	0	0
Coronary Bypass	<input type="radio"/> →	0	0	0	0
Diabetes Mellitus	<input type="radio"/> →	0	0	0	0
Emphysema	<input type="radio"/> →	0	0	0	0
Fracture of Hip or Forearm.....	<input type="radio"/> →	0	0	0	0
Glaucoma.....	<input type="radio"/> →	0	0	0	0
Hypertension (High Blood Pressure).....	<input type="radio"/> →	0	0	0	0
Hip Replacement.....	<input type="radio"/> →	0	0	0	0
Macular Degeneration of Retina.....	<input type="radio"/> →	0	0	0	0
Myocardial Infarction (Heart Attack).....	<input type="radio"/> →	0	0	0	0
Osteoporosis	<input type="radio"/> →	0	0	0	0
Pulmonary Embolus	<input type="radio"/> →	0	0	0	0
Scleroderma	<input type="radio"/> →	0	0	0	0
Stroke (CVA)	<input type="radio"/> →	0	0	0	0
Thyroid Conditions	<input type="radio"/> →	0	0	0	0
Adenoma	<input type="radio"/> →	0	0	0	0
Goiter.....	<input type="radio"/> →	0	0	0	0
Hyperthyroidism	<input type="radio"/> →	0	0	0	0
Hypothyroidism.....	<input type="radio"/> →	0	0	0	0
Nodule	<input type="radio"/> →	0	0	0	0
Other benign, thyroid condition, specify below	<input type="radio"/> →	0	0	0	0
Ulcer, Gastric or Duodenal.....	<input type="radio"/> →	0	0	0	0