Additional health checkup questionnaires

Last Name		Resident Reg. No.	
Given Name			

※ Please fill out this questionnaire if it is applicable to you.

Functional assessment of elderly **(66, 70, and 80 years of age)**

1. Do you receive inoculations with influenza vaccine every year?
① Yes ② No

2. Have you received vaccinations against pneumonia?
① Yes ② No

3. The following questions are about your ability to perform activities of daily living
Please read and answer the questions below.

1) If someone sets the table for your meal, you can eat by yourself without any help.
① Yes ② No

2) Can you put on your clothes without any help?
① Yes ② No

3) Can you go to the toilet by yourself?
① Yes ② No

4) When you take a bath or a shower, can you wash by yourself?
① Yes ② No

5) Can you prepare your meals?
① Yes ② No

6) Can you go to places that are of walking distance, such as a store, clinic, neighbor, or any public offices, by yourself?
① Yes ② No

4. About fall injury: Have you fell down during the last 6 months?
① Yes ② No

5. Urinary function: Do you have any difficulty in urinating or in holding your urine?
① Yes ② No

Evaluation of Cognitive Function Difficulty

Korean Dementia Screening Questionnaire – C

This questionnaire is for cognitive function difficulty. Please answer the following questions about your present condition compared to last year by ticking the appropriate box below. (This form should be completed by a guardian if the person in question cannot do so.)

Korean Dementia Screening Questionnaire - C	No (0 points)	Sometimes (1 point)	Almost every day (2 points)
1. I (He/She) do (does) not know what the day is today			
2. I (He/She) cannot find my own things.			
3. I (He/She) ask (asks) the same question over and over.			
4. I (He/She) forget (forgets) appointments.			
5. I (He/She) placed an object and I am (he/she is) not able to recall where the object is placed.			
6. I (He/She) cannot recall people's name or objects' name and has difficult time to say the name.			
7. I (He/She) do (does) not (understand conversations and I (he/she) ask (asks) someone about the conversation over and over.			
8. I (He/She) have (has) gotten lost in the middle of the road.			
9. I've (He/She has) lost the ability to calculate compared to last year. (example: I (he/she) cannot calculate the change or price)			
10. My (His/Her) personality has changed a lot.			
11. I (He/She) am (is) losing my (his/her) ability to use machinery. (washing machine, electric appliance, tracker, etc.)			
12. I (He/She) cannot organize things around the house.			
13. I (He/She) cannot choose the right clothes for the right occasion.			
14. I (He/She) cannot get to the destination alone by public transportation. (except in cases of physical difficulties, such as knee arthritis.)			
15. I (He/She) do (does) not want to change clothes even when they are dirty.			
Score	/ 30		

Mental Health (Depression) Assessment Tool

Patient Health Questionnaire-9: PHQ-9

The purpose of this questionnaire is to assess your level of depression. Although the questions are not for an exact diagnosis, it is very likely that you have depression if you receive high points. In such a case, we recommend that you see a psychiatrist for further evaluation.

How often have you suffered from the following symptoms **over the past two weeks**?

	Not at all	For a few days	For over a week	Almost every day
1. I am barely interested in my work.	0	1	2	3
2. I feel melancholy, depressed, or hopeless.	0	1	2	3
3. It is hard to fall asleep or I wake up very often during the night, or I sleep too much.	0	1	2	3
4. I feel exhausted or have no energy.	0	1	2	3
5. I have low appetite or eat too much.	0	1	2	3
6. I think that I am a bad person or a failure, or I feel like my family is unhappy because of me.	0	1	2	3
7. I cannot concentrate when I read a newspaper or watch TV.	0	1	2	3
8. I move or talk too slowly to the point that other people can notice it, or I wander or pace around too much because I feel anxious and restless.	0	1	2	3
9. I think I am better off dying, or I want to hurt myself in some way.	0	1	2	3
Points	/ 27			

Evaluation of Weight Control Habits

Examinee's name	

Subject of weight control habits evaluation ☐ Not applicable ☐

◆ Height:_____cm ◆ Weight:_____kg

◆ Waist:_____cm ◆ Body mass index:_____kg/m^2

1. Do you weigh more (10 kg) now than when you were in your teens or early 20s?

☐ Yes ☐ No

2. How many times have you tried to lose weight?

☐ Never ☐ 1~3

☐ Over 4 ☐ Always

3. Are you interested in losing weight?

☐ No ☐ A little bit interested ☐ Very interested

Weight Control Prescription

Examinee's name:

- Height: _____ cm
- Weight: _____ kg
- Waist: _____ cm
- Body mass index:_____ kg/m^2

1. You are
   - ☐ Normal.
   - ☐ Overweight.
   - ☐ Obese.

2. You have excessive fat around the abdomen.
   - ☐ Yes.
   - ☐ No

3. Because of your weight, your risk level of developing chronic diseases, such as CVDs, hypertension, diabetes, high cholesterol, among others, is
   - ☐ Low.
   - ☐ Normal.
   - ☐ A little increased.
   - ☐ More increased.
   - ☐ Sharply increased.
   - ☐ Very sharply increased.

4. Recommended weight goal:
   - ☐ Not applicable
   - ☐ The primary goal is to lower your current weight by ( )%.
     - Your primary target weight is ( ) kg.
     - The primary target weight achievement period is ( ) months.
     - The weight you need to lose every month is ( ) kg.

5. Prescription to treat obesity
   - ☐ Reduce meal portions.
   - ☐ Reduce snacks or midnight munchies.
   - ☐ Reduce eating out or fast food.
   - Get (☐ Smoking ☐ Drinking ☐ Exercising ☐ nutrition) prescription
   - ☐ Need to take medication
   - ☐ Others:

6. Health problems or conditions that can be improved if you keep the normal range of weight after weight loss.
   - ☐ Angina pectoris / cardiac infarction
   - ☐ Diabetes
   - ☐ Stroke
   - ☐ High blood pressure
   - ☐ High cholesterol
   - ☐ Peripheral blood vessel disease
   - ☐ Sleep apnea syndrome
   - ☐ Spine or bone problems
   - ☐ Incontinence
   - ☐ Gallbladder stone
   - ☐ Others:

7. Other comments (100 characters or less)

_____

☞ You need regular clinic visits to assist you in losing weight.

Physician's name/ Signature:

※ This prescription cannot be used for medication. It is only for developing life habits.

Evaluation of Diet Habits

Examinee's name	

1. I drink dairy products, such as milk, soybean milk, among others, more than 1 glass (over 200 mℓ) every day.

☐ Usually (5 points) ☐ Sometimes (3points) ☐ Never (1 point)

2. I eat meat, fish, egg, bean, or tofu more than 3 times a day.

☐ Usually (5 points) ☐ Sometimes (3points) ☐ Never (1 point)

3. I include vegetables in every meal.

☐ Usually (5 points) ☐ Sometimes (3points) ☐ Never (1 point)

4. I eat fruit (1 item) every day. (Including blended fruit juice)

☐ Regularly (5 points) ☐ Sometimes (3 points) ☐ Never (1 point)

5. How often do you have stir-fried food?

☐ More than 4 times a week (1 point) ☐ 2–3 times a week (3 points) ☐ Less than 1 time a week (5 points)

6. How often do you have food containing cholesterol, such as bacon, egg yolk, squid, etc.?

☐ More than 4 times a week (1 point) ☐ 2–3 times a week (3 points) ☐ Less than 1 time a week (5 points)

7. I eat one of these—ice cream, cake, snack or drinks (coffee, cola, sweet drinks)—every day.

☐ Usually (1 point) ☐ Sometimes (3points) ☐ Never (5 points)

8. I eat salted fish, soy sauce-seasoned dried vegetables, and other salty foods.

☐ Usually (1 point) ☐ Sometimes (3points) ☐ Never (5 points)

9. I always have my meals on time.

☐ Usually (5 points) ☐ Sometimes (3points) ☐ Never (1 point)

10. Do you eat at least 1 of each of the food groups, such as dairy products, meat or fish, fruits, vegetables, and grain, every day?

☐ 5 types (5 points) ☐ 4 types (3 points) ☐ Less than 3 types (1 point)

11. How often do you eat out?

☐ More than 5 times a week (1 point) ☐ 2–4 times a week (3 points) ☐ Less than once a week (5 points)

Total	

Prescription for Nutritional Life Habits

Examinee's name:

1. Present diet habits
   - □ Needs much improvement.
   - □ Normal.
   - □ Can prevent disease and maintain health

2. Improvement of diet habits
   - □ Drink more than 1 glass of milk, low-fat milk, or soybean milk containing calcium every day.
   - □ Eat a small portion of meat, tofu, bean, or fish more than 3 times a day.
   - □ Have vegetables during every meal.
   - □ Have seasoned, steamed, or roasted dishes, rather than fried dishes.
   - □ When you eat meat, if possible, eat lean meat and eat chicken and duck without the skin. Do not often eat eel, fish stomach, and fish eggs.
   - □ Do not have any sugary snacks, such as ice cream, snacks, or cake.
   - □ Eat more solid food items rather than soup and reduce intake of salty food.
   - □ Never skip breakfast and have regular meals.
   - □ Keep a balanced diet.
   - □ If possible, cut the number of times you eat out and if you do eat out, please avoid food that is too salty, too spicy, or too oily.

3. Health problems or conditions that can be improved through healthy eating habits.
   - □ High blood pressure
   - □ Heart disease
   - □ Stroke
   - □ Osteoporosis
   - □ Gout
   - □ Diabetes
   - □ Hyperlipidemia
   - □ Peripheral blood vessel trouble
   - □ Overweight
   - □ Others:

4. Other comments (100 characters or less)

_____

Physician's name / Signature:

※ This prescription cannot be used for medication. It is only for developing life habits.

Evaluation of Physical Exercise Habits

Examinee's name	

※ The following questions regard your exercise habits based on a **one week period.**
Please answer all the questions even if you are not physically active.
'High intensity exercise' refers to strenuous exercise that makes you considerably short of breath or makes your heart beat very fast. 'Moderate intensity' exercise refers to moderate physical activity that makes you slightly short of breath or makes your heart beat slightly faster.

1. First, think about your **work time** per day. This can be any activity in which you engage, such as work for money, work without making money, school life/education, household chores, farming, fishery, livestock work, and job-seeking activities.
(e.g. work, study, household chores, volunteer work, school gym class, etc.)

1-1. Does **your work** include at least 10 consecutive minutes of **high intensity exercise** that makes you considerably short of breath or makes your heart beat very fast?

※ High intensity physical exercise: Lifting or carrying heavy items (over 20kg), digging dirt, construction labor, carrying items up stairs, etc.

[1] Yes

[2] No (Go to Question 1-4)

1-2. How often do you engage in **high intensity exercise relating to your work** per week?

☐ days per week

1-3. How long do you engage in **high intensity exercise relating to your work** per day?

☐☐ hours and ☐☐ minutes per day

1-4. Does your work include at least 10 consecutive minutes of **moderate intensity exercise** that makes you slightly short of breath or your heart beat slightly faster?

※ Moderate intensity physical exercise: Power walking (during work), carrying light items, cleaning, childcare (giving a bath, holding a baby, etc.)

[1] Yes

[2] No (Go to Question 2)

1-5. How often do you engage in **moderate intensity exercise relating to your work** per week?

☐ days per week

1-6. How long do you engage in **moderate intensity exercise relating to your work** per day?

☐☐ hours and ☐☐ minutes per day

2. **Exclude the exercise you have already answered for the questions above.** The following questions are about how you move from one place to another.

※ Exercise while moving from one place to another: Going to work, going shopping, going grocery shopping, going to church, going to school/home, going to after-school activities, etc.

2-1. **Do you walk or ride a bicycle for at least 10 consecutive minutes when you go from one place to another?**

[1] Yes

[2] No (Go to Question 3)

2-2. **On average per week**, how often do you **walk or ride a bicycle** for at least 10 consecutive minutes **when going somewhere**?

☐ days per week

2-3. **On average per day**, how long do you walk or ride a bicycle **when going somewhere**?

☐☐ hours and ☐☐ minutes per day

3. **Exclude the exercise you have already answered for the above questions regarding physical activity relating to your work and moving from one place to another.** The following questions are about sports, exercise, and leisure activities.

3-1. Do you engage in at least 10 consecutive minutes of **high intensity sports, exercise, or leisure activity** that makes you considerably short of breath or makes your heart beat very fast?

※ e.g. Running, jumping rope, hiking, basketball game, swimming, badminton, etc.

[1] Yes

[2] No (Go to Question 3-4)

3-2. How often do you engage in **high intensity sports, exercise, or leisure activities** per week?

☐ days per week

3-3. How long do you engage in **high intensity sports, exercise, or leisure activities** per day?

☐☐ hours and ☐☐ minutes per day

3-4. Do you engage in at least 10 consecutive minutes of **moderate intensity sports, exercise, or leisure activity** that makes you slightly short of breath or makes your heart beat slightly faster?

※ e.g. Power walking, slow running (jogging), weight training (muscle exercise), golf, dance sports, Pilates, etc.

[1] Yes

[2] No (Go to Question 4)

3-5. How often do you engage in **moderate intensity sports, exercise, or leisure activities** per week?

☐ days per week

3-6. How long do you engage in **moderate intensity sports, exercise, or leisure activities** per day?

☐☐ hours and ☐☐ minutes per day

4. The following questions are about how long you sit or lie down per day at work or at home, or when you move to another place or spend time with your friends, **except during your sleeping hours.**

※ e.g. Sitting at your desk, sitting with your friends, going somewhere by car, bus, or train, reading a book, writing, playing cards, watching TV, playing games (Nintendo, computer, or PlayStation), using the Internet, listening to music, etc.

4-1. How many hours do you sit or lie down per day?

☐☐ hours and ☐☐ minutes per day

5. How many days did you do **muscle exercise** such as push-ups, sit-ups, dumbbell exercises, weight lifting, or horizontal bar exercise during the past one week?

[1] Not at all
[2] 1 day
[3] 2 days
[4] 3 days
[5] 4 days
[6] 5 days or more

6. Have you ever been told that you have to exercise by a doctor's recommendation because of a heart problem?
☐ Yes ☐ No

7. Have you ever experienced chest pains during exercise?
☐ Yes ☐ No

8. Have you ever experienced chest pains even when you did not exercise last month?
☐ Yes ☐ No

9. Have you ever lost your balance because of loss of consciousness or dizziness?
☐ Yes ☐ No

10. After trying a different exercise, have you ever experienced a bone or joint problem?
☐ Yes ☐ No

11. Have you ever received any prescription from a doctor because of heart problems or blood pressure?
☐ Yes ☐ No

12. Do you have any other reason for not exercising?
☐ Yes ☐ No

Prescription for Exercise Habits

Examinee's name:

1. Present exercise status
   - □ Insufficient for maintaining health.
   - □ Not enough to improve your health although health can be maintained.
   - □ Improving your health.

2. We recommend the following types of exercises to improve your health and quality of life.

   1) Types of exercise you should do

□ Fast walking	□ Walking	□ Mountain hiking
□ Swimming	□ Water activities	□ Riding a bicycle
□ Aerobics	□ Dance	□ Yoga
□ Weights	□ Others:	

   2) Exercise duration

   □ 10 minutes □ 15–30 minutes □ Over 30 minutes □ Others:

   3) Exercise frequency

   □ 1–2 times a week □ 3–4 times a week Over 5 times a week

3. Health problems or conditions can be improved through exercise.

□ Overweight	□ Stress	□ High blood pressure
□ Diabetes	□ Heart disease	□ Stroke
□ Hyperlipidemia	□ Osteoporosis	□ Pain in bones or joints
□ Injury from a fall	□ Depression	□ Others:

4. Other comments (100 characters or less)

_____

Physician's name / Signature:

※ This prescription cannot be used for medication. It is only for developing life habits.

Alcohol Habit Evaluation

Examinee's name	

Please answer the following questions about your present condition by ticking the appropriate box. This does not apply to nondrinkers, who do not drink at all.

1. How often do you drink alcoholic beverages?
   - ☐ Never (0 point)
   - ☐ Less than once a week (1 point)
   - ☐ 2–4 times a month (2 points)
   - ☐ 2–3 times a week (3 points)
   - ☐ Over 4 times a week (4 points)

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (Select one category corresponding to your drinking habits.)
   1) Soju
   - ☐ Not more than 0.5 bottle (0 points)
   - ☐ Not more than 1 bottle (1 point)
   - ☐ About 1.5 bottles (2 points)
   - ☐ About 2 bottles (3 points)
   - ☐ 2.5 bottles or more (4 points)

   2) Other types of liquor
   For hard liquor and wine, count number of glasses. Count by a bowl of makgeolli (rice wine) as a glass and a can or a bottle of beer as a glass. (Count 500 cc of draft beer as 1.3 glasses.)
   - ☐ 1–2 glasses (0 points)
   - ☐ 3–4 glasses (1 point)
   - ☐ 5–6 glasses (2 points)
   - ☐ 7–9 glasses (3 points)
   - ☐ 10 glasses or more (4 points)

3. How often do you drink over one bottle of soju or more than five cans of beer (2,000 cc draft beer)* at a time?
   (* Quantity consumed corresponding to 60 g of alcohol / more than five glasses in case of hard liquor, wine, or makgeolli)
   - ☐ None (0 points)
   - ☐ Less than once a month (1 point)
   - ☐ Once a month (2 points)
   - ☐ Once a week (3 points)
   - ☐ Almost every day (4 points)

4. How often during the last year have you found yourself not able to stop drinking once you started?
   - ☐ Never (0 points)
   - ☐ Less than once a month (1 point)
   - ☐ Once a month (2 points)
   - ☐ Once a week (3 points)
   - ☐ Almost every day (4 points)

5. How often during the last year have you failed to perform you daily work because of drinking?
   - ☐ Never (0 points)
   - ☐ Less than once a month (1 point)
   - ☐ Once a month (2 points)
   - ☐ Once a week (3 points)
   - ☐ Almost every day (4 points)

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session from the previous night?
   - ☐ Never (0 points)
   - ☐ Less than once a month (1 point)
   - ☐ Once a month (2 points)
   - ☐ Once a week (3 points)
   - ☐ Almost every day (4 points)

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   - ☐ Never (0 points)
   - ☐ Less than once a month (1 point)
   - ☐ Once a month (2 points)
   - ☐ Once a week (3 points)
   - ☐ Almost every day (4 points)

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   - ☐ Never (0 points)
   - ☐ Less than once a month (1 point)
   - ☐ Once a month (2 points)
   - ☐ Once a week (3 points)
   - ☐ Almost every day (4 points)

9. Have you or someone else been injured a result of your drinking?
   - ☐ Never (0 points)
   - ☐ Yes, but not in the last year. (2 points)
   - ☐ Yes, during the last year. (4 points)

10 Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you to cut down?
   - ☐ Never (0 points)
   - ☐ Yes, but not in the last year. (2 points)
   - ☐ Yes, during the last year. (4 points)

Total	

Stop Drinking or Drinking in Moderation Prescription

Examinees' name:

Summary

1) Alcohol Use Disorder Identification Test - Korean Revised Version (AUDIT-KR): _____ points,
2) Other illnesses that may be affected by drinking
   - ☐ Depression/Anxiety
   - ☐ Hypertension
   - ☐ Diabetes mellitus
   - ☐ Dyslipidemia (hyperlipidemia)
   - ☐ Gastrointestinal disease
   - ☐ Heart disease
   - ☐ Cerebral apoplexy (stroke)
   - ☐ Others:

1. Present drinking state
   - ☐ Normal
   - ☐ Danger
   - ☐ You have an alcohol use disorder.

2. Drinking abstinence or drinking in moderation prescription

1) You have proper drinking habits.
   - ☐ Maintain your current drinking habits in order to avoid dangerous drinking behaviors.

2) You need to improve your drinking habits.
   Your current drinking habits are at the dangerous level; therefore:
   - ☐ You should change your habits to fit within appropriate drinking behavior standards even though you do not presently have any physical complications.
   - ☐ You should not drink alcohol for a while until you recover from your physical complications (hepatic dysfunction, etc.).

   You have an alcohol use disorder; therefore:
   - ☐ You must stop drinking completely.

3 You require medical attention and drug treatment.
   - ☐ For an alcohol use disorder, you require medical attention and an adjuvant prescription for abstinence from alcohol.
   - ☐ You require medical attention for your physical complications.

3. Other comments (100 characters or less)

_____

Physician's name / Signature

※ This prescription cannot be used for medication. It is only for developing life habits.

Smoking Habits Evaluation

Examinee's name	

Find and check the item that corresponds to you. This does not apply to lifetime nonsmokers, former smokers, and electronic cigarette users.

1. Do you plan to stop smoking?
   - □ ① I plan to stop smoking within a month.
   - □ ② I plan to stop smoking within 6 months.
   - □ ③ I am thinking about stopping, but not within 6 months
   - □ ④ I do not have any intention to stop smoking right now.

2. Can you stop smoking right now (0-7)?
   □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7
   (Not at all) (For sure)

3. How soon do you light up your first cigarette after waking up?
   - □ Within 5 minutes (3 points)
   - □ Between 6 and 30 minutes (2 points)
   - □ Between 31 and 60 minutes (1 point)
   - □ After 60 minutes (0 point)

4. Do you have difficulty holding the urge to smoke in nonsmoking areas, such as churches, theaters, or libraries?
   - □ Yes (1 point)
   - □ No (0 point)

5. In which occasion is it most difficult for you to give up smoking?
   - □ The first cigarette in early morning (1 point)
   - □ Others (0 point)

6. How many cigarettes do you smoke a day?
   - □ Under 10 cigarettes (0 points)
   - □ 11–20 cigarettes (1 point)
   - □ 21–30 cigarettes (2 points)
   - □ Over 31 cigarettes (3 points)

7. Do you smoke more cigarettes within a few hours after waking up than the later hours?
   - □ Yes (1 point)
   - □ No (0 point)

8. Do you still want to smoke even when you are very sick?
   - □ Yes (1 point)
   - □ No (0 point)

Total	

Smoking Cessation Prescription

Examinee name:

1. Present smoking status
   □ Ex-smoker □ Current smoker

2. Nicotine dependency
   □ Low (0–3 points) □ Medium (4–6 points) □ High (7–10 points)

3. Stage of plan to quit smoking
   □ Stage prior to planning to quit smoking
   □ Planning stage to quit smoking
   □ Preparation stage to quit smoking
   □ Attempt to quit smoking
   □ Staying smoke-free

You can improve your quality of life if you stop smoking.

4. Smoking prescription
   □ Need education or counseling to stop smoking. Please read the stop-smoking brochure.
   □ Prescription of medications (□ Nicotine replacement therapy □ Bupropion □ Varenicline)
   □ We recommend that you join the nonsmoking program provided by the National Health Insurance Service.
   □ Refer to smoking cessation services (i.e., smoking cessation clinic or smoking cessation call center or quitline).
   □ Others:

   _____

   _____

5. How to overcome nicotine withdrawal symptoms and avoid the urge to smoke
   □ Drink enough water.
   □ It is helpful to chew gum or candies or eat snacks.
   □ Take a bath or shower with warm water.
   □ Relaxation and meditation are helpful.
   □ Take a walk and think about your motivation to quit smoking.
   □ Others

6. Other comments (100 characters or less)

   _____

You might require regular clinic visits to assist you with smoking cessation.

Physician's name / Signature:

※ This prescription cannot be used for medication. It is only for developing life habits.