DEMOGRAPHIC QUESTIONNAIRE

Date/Experimenter____

Screening: General Demographic information

REMIND POTENTIAL SUBJECT: CONFIDENTIAL

Subject code assigned if approved _________________

Have you ever participated in a study at the Centre for Studies on Human Stress? If so, can you recall what it entailed?

____

Name	
Sex	
Date of Birth/Age	
Phone Number	
Address/Email	
Number of Working/Studying Hours Per Week?	
Employment Title/Department	
Education	
First Language Proficiency	
Children (#) Age / Live at home?	
Height/Weight	

Civil Status:

☐ Single ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed

General Medical Information:

Smoker? ________ Social_______ If yes, how many per day?_________

How man cups of caffeine do you have per day? __________

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How many alcoholic drinks per day? _____ per week _____

Elicit drug use? _________ If yes, frequency and nature of the drug _________________

If yes, frequency and nature of drug(s)____

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Do you currently suffer from or have you ever had:

Allergies ___________________________________
Medications for these allergies ___________________________________

Cardio-vascular
Heart attack ☐
Heart Block ☐
Slow cardiac conduction ☐
Heart Failure ☐
Hypotension/Hypertension ☐
Other __________________

Neurological
Stroke ☐
Parkinson's ☐
Multiple sclerosis ☐
Head trauma with loss of consciousness ☐
Epilepsy/seizures ☐
Other ____________________

General Problems
Diabetes ☐
Cholesterol ☐
Glaucoma ☐
Kidneys ☐
Asthma, respiratory disease ☐
Infectious illness/sexually transmitted diseases ☐
Unstable thyroid ☐
Adrenal dysfunction ☐
Lupus ☐
Peptic or gastric ulcer ☐
Intestinal inflammatory disease (ex. Crohn's Disease) ☐
Inflammatory Bowel Disease or Syndrome ☐
Other ____________________

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Psychiatric problems (present or past or in 1st degree relatives)

Depression	☐ (talk it out with the subject, give examples…)
Bipolar disorder	☐
Anxiety disorders	☐
Schizophrenia	☐
Alcohol/drug abuse	☐
Dementia	☐
Other ___________________	

____
____
____
____
____

Have you had a cold or flu in the last 12 months ________________________

Do you take any Medication?

!!Contraceptives	☐ **(pill, patch, *IUD)**
Neuroleptics	☐ (thorazine, haldol, largactil, clozaril)
!Anti-depressants	☐ (for sleep disturbances, PMS, smoking cessation)
!Anxiolytics	☐ Prozac, Paxil, Pexeva, Zoloft, Effexor, Wellbutrin, Parnate
Glucocorticoids/steroids	☐ (creams, nasal spray, ventilator/pump asthma cortisone, prednisone, flonase…)
Mineralocorticoids	☐
Anti-convulsants	☐ diazepam, Ativan, Valium
Sedatives	☐
Cholesterol	☐
Anti-histamines	☐
Anti-inflammatory	☐

Other (____)

(Only for **WOMEN**)

!! What type of Contraceptive do you take? ______________________________

!! What is the brand name of your Oral Contraceptive? ____________________

!! How many milligrams do you take? ______________________________

!! What color is your pill? ______________________________

!! When was your last period? ______________________________

!! Menopause? At what age? ______________________________

Have you had general anesthesia or surgery in the last year? ________________

Have there been any major life events in the past year? (Example: breakup, death in the family, difficulty in school)

____

____

____

Consent to pass your name on for other studies (Yes/No)______________

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