

**Framingham Heart Study  
Cohort Examination 29 Forms**

**Numerical Data (Anthropometry)**

OMB No=0925-0216

12/31/2007

<b>Basic Information</b>	
_	<b>Site of Exam</b> (0=Heart Study, 1=Nursing home, 2=Residence, 3=Other, 9=Unknown)
_	<b>Marital Status</b> (1=Single, 2=Married, 3=Widowed, 4=Divorced, 5=Separated)
_ _ _	<b>Examiner's Number</b> for weight and height
_ _ _	<b>Weight</b> (to nearest pound, 999=Unknown)
_	<b>Protocol modification for weight</b> <span style="float: right;">0=No,1=Yes, 9=Unk/ND</span>
_	<b>Method used to obtain weight</b> (0=FHS protocol, clinic or field visit with portable scale, 1=recorded in NH chart, 2=Other write in _____)
_ _ * _ _ * _ _ _	<b>Date weight obtained</b> (mm/dd/yyyy)
_ _ * _ _	<b>Height</b> (inches, to next lower 1/4 inch, 99/99=Unknown) <span style="float: right;">88/88=field visit</span>
_	<b>Protocol modification for height.</b> <span style="float: right;">0=No,1=Yes, 9=Unk/ND</span>

<b>Technician's Blood Pressure</b> to nearest 2 mm Hg <span style="float: right;"><b>Clinic only</b></span>			
_ _ _  <b>Examiner's Number</b>		(not done at off-site visits)	
Systolic	Diastolic	BP cuff size	Protocol modification
_ _ _  999=Unk/ND	_ _ _  999=Unk/ND	_  0=pediatric, 1=regular,2=large adult, 3=thigh, 9=Unk/ND	_  0=No, 1=Yes, 9=Unk/ND

Comments on **all** protocol modifications:

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<b>EXAM 29 Procedures Sheet</b>	
<input type="checkbox"/>	<b>Informed Consent</b> 1=Consent signed 2=Consent signed, may qualify for Waiver, 3=waiver used, 4=Other _____
<input type="checkbox"/>	<b>ECG</b>
<input type="checkbox"/>	<b>Blood Drawn</b> 8=not drawn due to offsite visit
<input type="checkbox"/>	<b>Physician Medical History (Tech. Medical History, off-site)</b>
<input type="checkbox"/>	<b>Observed Physical Performance</b>
<input type="checkbox"/>	<b>CES-D</b>
<input type="checkbox"/>	<b>MMSE</b>
<input type="checkbox"/>	<b>Berkman Social Network</b>
<input type="checkbox"/>	<b>Physical function: Katz, Rosow-Breslau, Nagi, IADL</b>
<input type="checkbox"/>	<b>Leisure Time Cognitive and Physical Activities</b>
<input type="checkbox"/>	<b>Healthcare Preference Questions</b> 8=not eligible due to cognitive status
<input type="checkbox"/>	<b>Height</b> 8=not done due to offsite visit
<input type="checkbox"/>	<b>Weight</b>
<input type="checkbox"/>	<b>Socio-demographic, Nursing (Community) Services Use</b>

0=No  
1=Yes  
9=Unknown

<b>Exit Interview</b>	
_ _ _	<b>Examiner ID</b>
<input type="checkbox"/>	<b>Procedure Sheet Review</b>
<input type="checkbox"/>	<b>Referral Sheet Review</b>
<input type="checkbox"/>	<b>Left Clinic with all belongings</b> 8=n/a, offsite
<input type="checkbox"/>	<b>Feedback</b> 0=No feedback, 1=Positive feedback, 2=Negative feedback, 3=Other
<p>Comments _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

0=No  
1=Yes

TECH02

**Observed performance.**

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_ _ _	<b>Examiner's Number</b>
<b>HAND GRIP TEST</b> Measured to the nearest kilogram	
<b>Right hand</b>	
<b>Trial 1</b>	99=Unknown <span style="float:right;"> _ _ </span>
<b>Trial 2</b>	99=Unknown <span style="float:right;"> _ _ </span>
<b>Trial 3</b>	99=Unknown <span style="float:right;"> _ _ </span>
<b>Left hand</b>	
<b>Trial 1</b>	99=Unknown <span style="float:right;"> _ _ </span>
<b>Trial 2</b>	99=Unknown <span style="float:right;"> _ _ </span>
<b>Trial 3</b>	99=Unknown <span style="float:right;"> _ _ </span>
<b>Was this test completed?</b> (0=No, 1=Yes, 8=Not attempted, 9=Unknown) <span style="float:right;"> _ </span>	
<b>If not attempted or completed, why not?</b>	
1=Physical limitation	3=Other _____ write in <span style="float:right;"> _ </span>
2=Refused	9=Unknown

<b>PHYSICAL FUNCTION TEST</b> 10 seconds stand	
<b>Side by Side</b>	
<b>Was this test completed?</b> Held for 10 seconds (0=No, 1=Yes, 8=N/A, 9=Unknown) <span style="float:right;"> _ </span>	
<b>If not attempted or completed, why not?</b>	
1=Physical limitation	3=Other _____ write in <span style="float:right;"> _ </span>
2=Refused	9=Unknown
<b>Number of seconds held if less than 10</b>	99.99=Unknown <span style="float:right;"> _ _* _ _ </span>
<b>Semi-Tandem</b>	
<b>Was this test completed?</b> Held for 10 seconds (0=No, 1=Yes, 8=N/A, 9=Unknown) <span style="float:right;"> _ </span>	
<b>If not attempted or completed, why not?</b>	
1=Physical limitation	3=Other _____ write in <span style="float:right;"> _ </span>
2=Refused	9=Unknown
<b>Number of seconds held if less than 10</b>	99.99=Unknown <span style="float:right;"> _ _* _ _ </span>
<b>Tandem</b>	
<b>Was this test completed?</b> Held for 10 seconds (0=No, 1=Yes, 8=N/A, 9=Unknown) <span style="float:right;"> _ </span>	
<b>If not attempted or completed, why not?</b>	
1=Physical limitation	3=Other _____ write in <span style="float:right;"> _ </span>
2=Refused	9=Unknown
<b>Number of seconds held if less than 10</b>	99.99=Unknown <span style="float:right;"> _ _* _ _ </span>

TECH03

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_ _ _	<b>Examiner's Number</b>
<b>REPEATED CHAIR STANDS</b>	
<b>Was this test completed?</b> (0=No, 1=Yes, 8=Not attempted, 9=Unknown) <span style="float:right;"> _ </span> <b>If not attempted or completed, why not?</b> 1=Physical limitation                      3=Other _____ write in <span style="float:right;"> _ </span> 2=Refused      4=Test stopped at 60 sec      9=Unknown	
<b>IF OFFSITE visit, Chair height</b> (in inches, 99.99=Unknown) <span style="float:right;"> _ _ * _ _ </span>	
<b>Time to complete five stands in seconds</b> (If not completed in 60 sec – STOP)(99.99=Unk) <span style="float:right;"> _ _ * _ _ </span>	
<b>If less than five stands, enter the number</b> (9=Unk) <span style="float:right;"> _ </span>	
<b>Post-Repeated chair stand 30 second heart rate</b> (999=Unknown) <span style="float:right;"> _ _ _ </span>	
<b>MEASURED WALKS</b>	
<b>Walking aid used:</b> 0=No aid, 1=Cane, 2=Walker, 3=Other, 9=Unknown <span style="float:right;"> _ </span>	
<b>First Walk</b>	
<b>Was this test completed?</b> (0=No, 1=Yes, 8=Not attempted, 9=Unknown) <span style="float:right;"> _ </span> <b>If not attempted or completed, why not?</b> 1=Physical limitation                      3=Other _____ write in <span style="float:right;"> _ </span> 2=Refused                                      9=Unknown	
<b>Walk time</b> (in seconds, 99.99=Unknown) <span style="float:right;"> _ _ * _ _ </span>	
<b>Laser walk time</b> (in seconds, 99.99=Unknown) <span style="float:right;"> _ _ * _ _ </span>	
<b>Second Walk</b>	
<b>Was this test completed?</b> (0=No, 1=Yes, 8=Not attempted, 9=Unknown) <span style="float:right;"> _ </span> <b>If not attempted or completed, why not?</b> 1=Physical limitation                      3=Other _____ write in <span style="float:right;"> _ </span> 2=Refused                                      9=Unknown	
<b>Walk time</b> (in seconds, 99.99=Unknown) <span style="float:right;"> _ _ * _ _ </span>	
<b>Laser walk time</b> (in seconds, 99.99=Unknown) <span style="float:right;"> _ _ * _ _ </span>	
<b>Quick Walk</b>	
<b>Was this test completed?</b> (0=No, 1=Yes, 8=Not attempted, 9=Unknown) <span style="float:right;"> _ </span> <b>If not attempted or completed, why not?</b> 1=Physical limitation                      3=Other _____ write in <span style="float:right;"> _ </span> 2=Refused                                      9=Unknown	
<b>Walk time</b> (in seconds, 99.99=Unknown) <span style="float:right;"> _ _ * _ _ </span>	
<b>Laser walk time</b> (in seconds, 99.99=Unknown) <span style="float:right;"> _ _ * _ _ </span>	

TECH04

### Mini-mental State Exam

*I'm going to ask some questions that require concentration and memory. Some questions are more difficult than others and some will be asked more than one time.*

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<input style="width: 40px; height: 20px;" type="text"/>	<b>Examiner's Number</b> for Cognitive Function -- MMSE
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<b>SCORE CORRECT</b> No Try=6, Unknown=9	<b>Write all responses on exam form</b> (score 1 point for each correct response)
0 1 2 3 6 9	<b>What Is the Date Today?</b> (Month, day, year, correct score=3)
0 1 6 9	<b>What Is the Season?</b>
0 1 6 9	<b>What Day of the Week Is it?</b>
0 1 2 3 6 9	<b>What Town, County and State Are We in?</b>
0 1 6 9	<b>What Is the Name of this Place?</b> (any appropriate answer all right, for instance my home, nursing home, street address, heart study...max score=1)
0 1 6 9	<b>What Floor of the Building Are We on?</b>
0 1 2 3 6 9	<b>I am going to name 3 objects. After I have said them I want you to repeat them back to me. Remember what they are because I will ask you to name them again in a few minutes: Apple, Table, Penny</b>
<input style="width: 40px; height: 20px;" type="text"/>	<b>Now I am going to spell a word forward and I want you to spell it backwards. The word is world. W-O-R-L-D. Please Spell it in Reverse Order.</b> <b>Write in Letters,</b> _____ (Letters Are Entered and Scored Later) Score as: 66666=Not administered for reason unrelated to cognitive status 00000=Administered, but couldn't do 99999=Unknown
0 1 2 3 6 9	<b>What are the 3 objects I asked you to remember a few moments ago?</b>

## Mini-mental State Exam

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SCORE CORRECT No Try=6, Unknown=9	<b>Write all responses on exam form.</b> (score 1 point for each correct answer)
0 1 6 9	<b>What Is this Called? (Watch)</b>
0 1 6 9	<b>What Is this Called? (Pencil)</b>
0 1 6 9	<b>Please Repeat the Following: "No Ifs, Ands, or Buts." (Perfect=1)</b>
0 1 6 9	<b>Please Read the Following &amp; Do What it Says</b> (performed=1, code 6 if low vision)
0 1 6 9	<b>Please Write a Sentence</b> (code 6 if low vision)
0 1 6 9	<b>Please Copy this Drawing</b> (code 6 if low vision)
0 1 2 3 6 9	<b>Take this piece of paper in your right hand, fold it in half with both hands, and put in your lap</b> (score 1 for each correctly performed act, code 6 if low vision)

No Yes Maybe Unk (coding for below)	<b>Factor Potentially Affecting Mental State Testing</b>
0 1 2 9	Illiterate or low education
0 1 2 9	Not fluent in English
0 1 2 9	Poor eyesight
0 1 2 9	Poor hearing
0 1 2 9	Depression / possible depression
0 1 2 9	Aphasia
0 1 2 9	Coma
0 1 2 9	Parkinsonism or neurologically impaired
0 1 2 9	Other

### Socio-demographics

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<input type="text"/>	<b>Examiner's Number</b> for Socio-demographics
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Socio-demographics																			
<input type="text"/>	<b>Where do you live?</b> (0=Private residence, 1=Nursing home, 2=Other institution, such as: assisted living or retirement community, 9=Unknown)																		
<input type="text"/>	<b>Does anyone live with you?</b> (0=No, 1=Yes, 9=Unknown) Code Nursing Home Residents as NO to these questions																		
If Yes ☞ If 0 or 9, skip down	<table style="width:100%"> <tr> <td style="width:10%; text-align: center;"> <input type="text"/> </td> <td style="width:50%;">Spouse</td> <td style="width:40%;">0=No</td> </tr> <tr> <td style="text-align: center;"> <input type="text"/> </td> <td>Significant Other</td> <td>1=Yes, less than 3 months per year</td> </tr> <tr> <td style="text-align: center;"> <input type="text"/> </td> <td>Children</td> <td>2=Yes, at least 3 months per year</td> </tr> <tr> <td style="text-align: center;"> <input type="text"/> </td> <td>Friends</td> <td>9=Unknown</td> </tr> <tr> <td style="text-align: center;"> <input type="text"/> </td> <td>Relatives</td> <td></td> </tr> <tr> <td style="text-align: center;"> <input type="text"/> </td> <td>Pets</td> <td></td> </tr> </table>	<input type="text"/>	Spouse	0=No	<input type="text"/>	Significant Other	1=Yes, less than 3 months per year	<input type="text"/>	Children	2=Yes, at least 3 months per year	<input type="text"/>	Friends	9=Unknown	<input type="text"/>	Relatives		<input type="text"/>	Pets	
<input type="text"/>	Spouse	0=No																	
<input type="text"/>	Significant Other	1=Yes, less than 3 months per year																	
<input type="text"/>	Children	2=Yes, at least 3 months per year																	
<input type="text"/>	Friends	9=Unknown																	
<input type="text"/>	Relatives																		
<input type="text"/>	Pets																		
<input type="text"/>	<b>Are you Currently working at a paying job or doing unpaid volunteer or community work?</b> (0=No,1=Yes, full time(>=32 hrs/week), 2=Yes, part time (<32 hrs/week), 9 =Unknown)																		
<input type="text"/>	<b>During the past 6 months (180 days) how many days were you so sick that you were unable to carry out your usual activities?</b> (999=Unknown)																		

** Proxy may NOT be used to help complete this section **	
<input type="text"/>	<b>In general, how is your health now:</b> (1=Excellent, 2=Good, 3=Fair, 4=Poor, 9=Unkn)
<input type="text"/>	<b>Compare your health to most people your own age:</b> (1=Better, 2=About the same, 3=Worse than most people your own age, 9=Unknown)

## Instrumental Activities of Daily Living (Lawton IADL)

(Not administered to nursing home residents)

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*Instructions: Use the prompt cards when asking these questions. If code=0 –write in definition of “some help”*

_ _	<b>1. Can you use the phone:</b>
	01 completely unable to use the phone
	02 with some help
	03 without help (operates phone on own initiative, looks up, dials number, etc.)
_ _	<b>2. Can you get to places out of walking distance:</b>
	01 completely unable to travel unless special arrangements are made (taxi or car with human assistance)
	02 with some help (when assisted or accompanied by another)
	03 without help (travels independently: drives car, public transportation or use of taxi)
_ _	<b>3. Can you go shopping for groceries :</b>
	01 completely unable to do any shopping
	02 with some help (needs to be accompanied on any shopping trip)
	03 without help
	88 resides in assisted living facility, does not do
_ _	<b>4. Can you prepare your own meals:</b>
	01 completely unable to prepare meals (needs meals prepared and served)
	02 with some help (heat and serve prepared meals)
	03 without help (plans, prepares, serves meals)
	88 resides in assisted living facility, does not do
_ _	<b>5. Can you do your own housework :</b>
	01 completely unable to do any housework
	02 with some help
	03 without help (performs light daily tasks – dishwashing, bed making, etc).
	88 resides in assisted living facility, does not do
_ _	<b>6. Can you do your own handyman work:</b>
	01 completely unable to do any handyman work
	02 with some help
	03 without help
	88 resides in assisted living facility, does not do
_ _	<b>7. Can you do your own laundry:</b>
	01 completely unable to use the laundry
	02 with some help (such as using laundry service)
	03 without help (does personal laundry completely)
	88 resides in assisted living facility, does not do
_ _	<b>3. A. Do you take medicines or use any medications?</b>
	01 Yes <i>Go to question 8B</i>
	02 No <i>Go to question 8C</i>
_ _	<b>3. B. Do you take your own medicines:</b>
	01 completely unable to take own medicine
	02 with some help (if someone prepares it or reminds you)
	03 without help (in the right doses at the right time)
_ _	<b>3. C. If you had to take medicine, could you do it:</b>
	01 completely unable to take own medicine
	02 with some help (if someone prepares it or reminds you)
	03 without help (in the right doses at the right time)
_ _	<b>8. Can you manage your own money:</b>
	01 completely unable to manage own money
	02 with some help (manages day-to-day purchases, needs help with banking, major purchases)
	03 without help

## Self-Reported Physical Function.

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_ _ _	<b>Examiner's Number</b> for Rosow-Breslau and Nagi Quest.	
<b>Nagi Questions</b>		
<p><b>For each thing tell me whether you have</b></p> <p>(0) No Difficulty  (1) A Little Difficulty  (2) Some Difficulty  (3) A Lot Of Difficulty  (4) Unable To Do  (5) Don't Do On MD Orders or Institutional Orders  (6) Unable to Assess Difficulty Because Not Done as Part of Daily Activities  (9) Unknown</p>		
_	Pulling or pushing large objects like a living room chair	
_	Either stooping, crouching, or kneeling	
_	Reaching or extending arms below shoulder level	
_	Reaching or extending arms above shoulder level	
_	Either writing, or handling or fingering small objects	
_	Standing in one place for long periods, say 15 minutes	
_	Sitting for long periods, say 1 hour	
_	Lifting or carrying weights under 10 pounds (like a bag of potatoes)	
_	Lifting or carrying weights over 10 pounds (like a very heavy bag of groceries)	
<b>Rosow-Breslau Questions</b>		
_	Are you able to do heavy work around the house, like shoveling snow or washing windows, walls, or floors without help?	0=No, unable to do 1=Yes, independent 2=Does not do 9=Unknown
_	Are you able to walk half a mile without help? (About 4-6 blocks)	
_	If you had to, could you do all the housekeeping yourself? (like washing clothes and cleaning)	
_	Do you drive now?	0=No 1=Yes, currently 2=Yes, not now 9=Unknown
if no then ☞	_	<b>Reason for <u>not</u> driving now</b> (1=Health, 2=Other non-health reason, 3=never licensed, 8=N/A, current driver, 9=Unknown)

## Self-Reported Physical Function.

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<input style="width: 40px; height: 20px; border: none; border-bottom: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: none; border-bottom: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: none; border-bottom: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: none; border-bottom: 1px solid black;" type="text"/>	<b>Examiner's Number</b> for Physical Function
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### Katz: Activities of Daily Living

**During the Course of a Normal Day, Can you do the following activities independently or do you need human assistance or the use of a device?** Coding: 0=No help needed, independent, 1=Uses device, independent, 2=Human assistance needed, minimally dependent, 3=Dependent, 4=Do not do during a normal day, 9=Unknown

<input type="checkbox"/>	<b>Dressing</b> (undressing and redressing) Devices such as: velcro, elastic laces;
<input type="checkbox"/>	<b>Bathing</b> (including getting in and out of tub or shower) Devices such as: bath chair, long handled sponge, hand held shower, safety bars;
<input type="checkbox"/>	<b>Eating</b> Devices such as: rocking knife, spork, long straw, plate guard.
<input type="checkbox"/>	<b>Transferring</b> ( getting in and out of a chair) Devices such as: sliding board, grab bars, special seat;
<input type="checkbox"/>	<b>Toileting Activities</b> (using bathroom facilities and handle clothing) Devices such as: special toilet seat, commode;
<input type="checkbox"/>	<b>Bladder Continence</b> (ask if person has "accidents") (code=5 if use special products) Devices such as: external catheter, drainage bags, ileal appliance, protective devices;
<input type="checkbox"/>	<b>Bowel Continence</b> (ask if person has "accidents") (code=5 if use special products) Devices such as: suppositories, bedpan, regular enemas, colostomy;
<input type="checkbox"/>	<b>Walking on Level Surface about 50 Yards</b> Devices such as: cane, crutches, or walker;
<input type="checkbox"/>	<b>Walking up and down One Flight Stairs</b> Devices such as: handrail, cane.

### Compensatory Strategies for Walking in the Home

(Do not administer to Nursing home residents)

<input type="checkbox"/>	<b>Is there a step to go into your home (entry way step)?</b>	
<input type="checkbox"/>	<b>In your home, are the bedroom, bathroom, and kitchen all on the same floor (multilevel living)?</b>	
<input type="checkbox"/>	<b>When you walk, do you use a cane at home?</b>	0=No 1=Yes
<input type="checkbox"/>	<b>When you walk, do you use a walker at home?</b>	8=Refused 88=n/a, reside
<input type="checkbox"/>	<b>Do you use a wheelchair at home?</b>	in assisted living
<input type="checkbox"/>	<b>When you walk, do you reach out for or hold on to the furniture or walls at home?</b>	9=Don't know
<input type="checkbox"/>	<b>When you walk, do you hold on to another person at home?</b>	
<input type="checkbox"/>	<b>When you walk in the dark, do you hold on to the furniture or walls?</b>	
<input type="checkbox"/>	<b>When you walk in the dark, do you hold on to another person?</b>	

### Activities Questions.

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<input type="text"/> <input type="text"/> <input type="text"/>	<b>Examiner's Number</b> for Activities Questions.		
<b>Use of Nursing and Community Services</b>			
<input type="checkbox"/>	<b>Have you been admitted to a nursing home (or skilled facility) since your last exam or medical history update?</b> (0=No, 1=Yes, 9=Unknown)		
<input type="checkbox"/>	<b>Since your last exam, have you been visited by a nursing service, or used home, community, or outpatient programs?</b> (0=No, 1=Yes, 9=Unknown)		
<b>if yes, continue and below</b>	<b>Currently</b>	<b>Since last exam</b>	<b># months used</b>
	0=No At least once per: 1=Day 2=Week 3=Month 4=Other(write in) _____ 9=Unknown		0=None 1=One month or less 2-98=Put in actual number of months used 99=Unknown
	<b>Currently</b>	<b>Since Last Exam</b>	<b># Months Used Since Last Exam</b>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
			<b>Home health aides</b>
			<b>Homemaker visits</b>
			<b>Visiting Nurses</b>
			<b>Other (write in) _____</b>

<input type="checkbox"/>	<b>Are you in bed or a chair for most or all of the day (on the average)?</b> Note: this is a lifestyle question, not related to poor health. (0=No, 1=Yes, 9=Unknown)	
<input type="checkbox"/>	<b>Do you need a special aid (wheelchair, cane, walker) to get around?</b> (0=No, 1=Yes, 9=Unknown)	
<b>if yes then</b>	<b>If yes, which of the following equipment do you use?</b>	
	<input type="checkbox"/>	<b>Cane or walking stick</b>
	<input type="checkbox"/>	<b>Wheelchair</b>
	<input type="checkbox"/>	<b>Walker</b>
	<input type="checkbox"/>	<b>Other (Write in) _____</b>
		0=No 1=Yes, always 2=Yes, sometimes 9=Unknown

### Falls and Fractures

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<input style="width: 30px; height: 20px;" type="text"/>	<b>Examiner's Number</b> for Falls and Fractures
<input style="width: 30px; height: 20px;" type="text"/>  if yes, fill	<b>Since your last exam have you accidentally fallen and hit the floor or ground?</b> (code as no if during sports activity) (0=No, 1=Yes, 2=Maybe, 9=Unk)
	<input style="width: 30px; height: 20px;" type="text"/> <b>How many times did you fall in the past year?</b> (99=Unknown)
<input style="width: 30px; height: 20px;" type="text"/>  If 1 or 2, fill	<b>Since your last exam or medical history update have you broken any bones?</b> (Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown)
	<input style="width: 30px; height: 20px;" type="text"/> <b>Location of 1<sup>st</sup> fracture</b>
	<input style="width: 30px; height: 20px;" type="text"/> <b>Location of 2<sup>nd</sup> fracture</b>
	<input style="width: 30px; height: 20px;" type="text"/> <b>Location of 3<sup>rd</sup> fracture</b>
<b>Location Fracture Code</b>	
1. Clavicle (collar bone)	
2. Upper arm (humerus) or elbow	
3. Forearm or wrist	
4. Hand	
5. Back (If disc disease only, code as no)	
6. Pelvis	
7. Hip	
8. Leg	
9. Foot	
10. Other (specify) _____	

## Health Care Preferences Questionnaire.

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<input type="text"/>	<b>Examiner's Number</b> for Health Care Preferences
----------------------	--

**Intro:** People have many ideas about health and health care. Understanding these ideas is crucial to improving care. We are interested in learning what you believe to be the most important considerations at this point in your life. There are no right or wrong answers. We are simply interested in your opinions. We understand that this is a sensitive topic. Your participation is voluntary and you may choose to stop answering questions at any time.

<input type="text"/>	<b>Would you like to proceed?</b> (0=No, 1=Yes, 8=not done due to cognitive status)
----------------------	---

I would like to ask about the kinds of preparation you may have made in case you become too sick to make your own medical decisions.

<input type="text"/> <b>If yes, ask for each one</b> <small>☞</small>	<b>1. Have you talked about your wishes for medical care toward the end of your life with anyone since your last exam?</b>		
	<input type="text"/> Spouse (if applicable), child, grandchild	<b>0=no</b> <b>1=yes</b> <b>8= prefer not to answer</b> <b>9=don't know</b>	
	<input type="text"/> Other family member		
	<input type="text"/> Physician or other health care professional		
	<input type="text"/> Clergy		
	<input type="text"/> Attorney		
	<input type="text"/> Friends		
	<input type="text"/> Other, write in _____		

If question 1 = 0, 8, or 9, go to question 2a; if question 1 = 1, go to 2b.

<b>2a. Who would you want to initiate a conversation with you regarding end of life issues?</b>			
<b>ask for each one</b> <small>☞</small>	<input type="text"/> Spouse (if applicable), child, grandchild		
	<input type="text"/> Other family member	<b>0=no</b> <b>1=yes</b> <b>8= prefer not to answer</b> <b>9=don't know</b>	
	<input type="text"/> Primary care physician		
	<input type="text"/> Physician specialists (such as cardiologist, oncologist)		
	<input type="text"/> Clergy		
	<input type="text"/> Attorney		
	<input type="text"/> Friends		
	<input type="text"/> Other, write in _____		
	<input type="text"/> No one		

<b>2b. Who else would you want to initiate a conversation with you regarding end of life issues?</b>			
<b>ask for each one</b> <small>☞</small>	<input type="text"/> Spouse (if applicable), child, grandchild		
	<input type="text"/> Other family member	<b>0=no</b> <b>1=yes</b> <b>7=had past conversation</b> <b>8= prefer not to answer</b> <b>9=don't know</b>	
	<input type="text"/> Primary care physician		
	<input type="text"/> Physician specialists (such as cardiologist, oncologist)		
	<input type="text"/> Clergy		
	<input type="text"/> Attorney		
	<input type="text"/> Friends		
	<input type="text"/> Other, write in _____		
	<input type="text"/> No one		

## Health Care Preferences Questionnaire.

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<input type="checkbox"/>	<p><b>3. Since your last exam, have you and your doctor discussed any particular wishes you have about the care you would want to receive if you were dying?</b> (0=no, 1=yes, 8= prefer not to answer, 9=don't know)</p>
<p><b>if no,</b> ☞</p>	<p><input type="checkbox"/> <b>Do you want your doctor to initiate a conversation with you about your wishes for care if you were dying?</b> (0=no, 1=yes, 8= prefer not to answer, 9=don't know)</p>
<input type="checkbox"/>	<p><b>4. How comfortable are you with talking about death?</b> 1=very comfortable, 2=somewhat comfortable, 3=not very comfortable, 4=not at all comfortable, 8= prefer not to answer, 9=don't know</p>
<input type="checkbox"/>	<p><b>5. Have you filled out a Health Care Proxy form naming someone who could make decisions about your medical treatment if you could not speak for yourself?</b> (0=no, 1=yes, 2=completed advanced directive not sure which form (i.e. HCP form vs. living will) , 8= prefer not to answer, 9=don't know)</p>
<p><b>if yes,</b> ☞</p>	<p><input type="checkbox"/> <b>Who is your health care proxy?</b> (1=spouse, 2=child, 3=sibling, 4=other relative, 5=friend, 6=attorney, 7=other, write in _____, 9=don't know)</p>
<input type="checkbox"/>	<p><b>6. Have you filled out a living will giving directions for the kind of medical treatment you would want if ever you could not speak for yourself?</b> (0=no, 1=yes, 2=completed advanced directive not sure which form (i.e. HCP form vs. living will) , 8= prefer not to answer, 9=don't know)</p>
<input type="checkbox"/>	<p><b>7. If you were seriously ill, would you prefer care 0) to extend your life, even if it meant more pain and discomfort, or 1) to relieve pain and discomfort, even if it meant not living as long.</b> 0= Extend life as much as possible, 1= Relieve pain or discomfort as much as possible 8= prefer not to answer 9=Don't know</p>

## Health Care Preferences Questionnaire.

OMB No=0925-0216 12/31/2007

*I'm going to read some statements that describe situations that sometimes happen to people particularly at the end of their life. We are asking these questions of everyone regardless of how well or sick they are now. For each statement please tell me if you would be very willing, somewhat willing, somewhat unwilling, very unwilling or would rather die than put up with the situation. Please think about the situation as if you would be living this way for the rest of your life.*

	Very willing	Some what willing	Some what unwilling	Very unwilling	Rather die	Prefer not to answer	Don't know
<b>8. Being in a great deal of pain unrelieved by medicines?</b>	1	2	3	4	5	8	9
<b>9. Being attached to a ventilator or respirator all the time?</b>	1	2	3	4	5	8	9
<b>10. Being fed through a tube all the time?</b>	1	2	3	4	5	8	9
<b>11. Being unconscious or in coma all the time?</b>	1	2	3	4	5	8	9
<b>12. Forgetting or being confused all the time?</b>	1	2	3	4	5	8	9

**13. Where would you prefer to die?**  
1=home, 2=hospital, 3=nursing home 4=hospice, 5= other, 8= prefer not to answer 9=don't know

**14. What are the chances that you will be able to take care of yourself 12 months from now?**  
1= 90% or better, 2= about 75% 3= about 50-50, 4= about 25% 5= 10% or less, 8= prefer not to answer 9=don't know

**15. What do you think the chances are that you would live 12 months or more?**  
1= 90% or better, 2= about 75% 3= about 50-50, 4= about 25% 5= 10% or less, 8= prefer not to answer 9=don't know

*Now I am going to ask a question about how your religious/spiritual beliefs might influence your medical care.*

**16. To what extent do your religious beliefs help you cope with or handle serious illness?**  
0=not at all, 1=to a small extent, 2= to a moderate extent, 3=to a large extent, 4=it's the most important thing that keeps you going, 8= prefer not to answer, 9=don't know

**Thank you very much for you willingness to share this information. This form has been completed for research purposes and does not serve as a legal document. For more information on how to obtain legal forms please speak to your physician.**

**TECH15**

# Interviewer Feedback: Health Care Preferences Questionnaire

OMB No=0925-0216 12/31/2007

	<b>Examiner's Number</b>
<input type="checkbox"/>	<b>1. Did the participant choose to stop before completing all 16 questions?</b> (0=No, 1=Yes, 9=Unknown)
if yes, ☞	<input type="checkbox"/> <b>Why did they stop?</b> (0=no reason given, 1=refused to continue, 2=too upsetting, 3=other) _____ _____
	<input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/> <b>What question did they stop at? (write in number)</b>
<b>Additional Comments:</b>	_____ _____ _____
<input type="checkbox"/>	<b>2. Did the participant seem upset or bothered by any of the questions that were asked?</b> (0=No, 1=Yes, 9=Unknown)
if yes, ☞	<input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/> <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/> <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/> <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/> <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>
	<b>Which questions? (write in number(s))</b>
<b>Additional Comments:</b>	_____ _____ _____
<input type="checkbox"/>	<b>3. Were there any questions that the participant had particular difficulty understanding?</b> (0=No, 1=Yes, 9=Unknown)
if yes, ☞	<input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/> <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/> <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/> <input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>
	<b>Which questions? (write in number(s))</b>
<b>Additional Comments:</b>	_____ _____ _____

TECH16

### Berkman Social Network Questionnaire. Tech-administered

OMB No=0925-0216 12/31/2007

*The next questions ask about your social support. Please tell me the response that most closely describes your current situation.*

□□□□	<b>Examiner's Number</b> for Berkman Questionnaire.					
<b>For each question please circle one answer</b>						
Coding scheme	<b>None</b>	<b>1 or 2</b>	<b>3 to 5</b>	<b>6 to 9</b>	<b>10 or more</b>	<b>Unknown</b>
<b>1. How many <i>close friends</i> do you have, people that you feel at ease with, can talk to about private matters?</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>9</b>
<b>2. How many of these <i>close friends</i> do you see at least once a month?</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>9</b>
<b>3. How many <i>relatives</i> do you have, people, that you feel at ease with, can talk to about private matters?</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>9</b>
<b>4. How many of these <i>relatives</i> do you see at least once a month?</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>9</b>

<b>5. Do you participate in any groups such as a senior center, social or work group, religious connected group, self-help group, or charity, public service or community group?</b>		
<b>Circle one answer</b>		
No (Code=0)	Yes (Code=1)	Unknown (Code=9)

<b>6. About how often do you go to religious meetings or services?</b>						
<b>Circle one answer</b>						
Never or almost never <b>0</b>	Once or twice a year <b>1</b>	Every few months <b>2</b>	Once or twice a month <b>3</b>	Once a week <b>4</b>	More than once a week <b>5</b>	Unknown <b>9</b>

TECH17

**Berkman Social Network Questionnaire. Tech- Administered**

OMB No=0925-0216 12/31/2007

<b>7. Do you have health insurance other than Medicare or Medicaid?</b>		
Circle one answer		
<b>No</b> (Code=0)	<b>Yes</b> (Code=1)	<b>Unknown</b> (Code=9)

For each question please circle one answer						
Coding Scheme	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Unknown
<b>8. Is there someone available to you whom you can count on to listen to you when you need to talk?</b>	0	1	2	3	4	9
<b>9. Is there someone available to give you good advice about a problem?</b>	0	1	2	3	4	9
<b>10. Is there someone available to you who shows you love and affection?</b>	0	1	2	3	4	9
<b>11. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?</b>	0	1	2	3	4	9
<b>12. Do you have as much contact as you would like with someone you feel close to, someone in whom you can trust and confide?</b>	0	1	2	3	4	9

TECH18

### Leisure Time Cognitive and Physical Activities.

OMB No=0925-0216

12/31/2007

□□□□	<b>Examiner's Number</b> for Leisure time activities.
------	---

*During the past year, how often have you participated in the following leisure time activities?*

Questions to be answered  Circle best answer for each question	Never	Daily  (7 days per week)	Several days per week  (2-6 days per week)	Once weekly  (1 day per week)	Monthly  (once a month)	Occasionally  (≤ once a month)
<b>1. Reading books/newspapers</b>	0	1	2	3	4	5
<b>2. Writing for pleasure</b>	0	1	2	3	4	5
<b>3. Doing crossword puzzles</b>	0	1	2	3	4	5
<b>4. Playing board games or cards</b>	0	1	2	3	4	5
<b>5. Participating in organized group discussions</b>	0	1	2	3	4	5
<b>6. Group exercises</b>	0	1	2	3	4	5
<b>7. Housework</b>	0	1	2	3	4	5
<b>8. Playing musical instruments</b>	0	1	2	3	4	5

TECH19

**CES-D Scale**

OMB No=0925-0216 12/31/2007

□□□□	Examiner's Number for CES-D Scale
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*The next questions ask about your feelings. For each of the following statements, please say if you felt that way during the past week.*

Questions to be answered  Circle best answer for each question	Rarely or none of the time  (less than 1 day)	Some or a little of the time  (1-2 days)	Occasionally or moderate amount of time  (3-4 days)	Most or all of the time  (5-7 days)	Unknown
1. I was bothered by things that usually don't bother me.	0	1	2	3	9
2. I did not feel like eating, my appetite was poor.	0	1	2	3	9
3. I felt that I could not shake off the blues, even with help from my family and friends.	0	1	2	3	9
4. I felt that I was just as good as other people.	0	1	2	3	9
5. I had trouble keeping my mind on what I was doing.	0	1	2	3	9
6. I felt depressed.	0	1	2	3	9
7. I felt that everything I did was an effort.	0	1	2	3	9
8. I felt hopeful about the future.	0	1	2	3	9
9. I thought my life had been a failure.	0	1	2	3	9
10. I felt fearful.	0	1	2	3	9
11. My sleep was restless.	0	1	2	3	9
12. I was happy.	0	1	2	3	9
13. I talked less than usual.	0	1	2	3	9
14. I felt lonely.	0	1	2	3	9
15. People were unfriendly.	0	1	2	3	9
16. I enjoyed life.	0	1	2	3	9
17. I had crying spells.	0	1	2	3	9
18. I felt sad.	0	1	2	3	9
19. I felt that people disliked me	0	1	2	3	9
20. I could not "get going"	0	1	2	3	9

TECH20

### Proxy form

OMB No=0925-0216

12/31/2007

<input type="checkbox"/>	<b>Proxy used to complete this exam</b> (0=No, 1=Yes, 1 proxy, 2=Yes, more than 1 proxy, 9=Unk)	
<b>if yes, fill</b> ☞	<b>Proxy Name</b> _____	
	<input type="checkbox"/>	<b>Relationship</b> (1=1 <sup>st</sup> Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unknown)
	_ _ * _ _	<b>How long have you known the participant?</b> (Years, months; 99.99=Unk) example: 3m=00*03
	<input type="checkbox"/>	<b>Are you currently living in the same household with the participant?</b> (0=No, 1=Yes, 9=Unk)
	<input type="checkbox"/>	<b>How often did you talk with the participant during the prior 11 months?</b> (1=Almost every day, 2=Several times a week, 3=Once a week, 4=1 to 3 times per month, 5=Less than once a month, 9=Unknown)
<hr/>		
	<b>Proxy Name</b> _____	
<input type="checkbox"/>	<b>Relationship</b> (1=1 <sup>st</sup> Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unknown)	
_ _ * _ _	<b>How long have you known the participant?</b> (Years, months; 99.99=Unk) example: 3 m=00*03	
<input type="checkbox"/>	<b>Are you currently living in the same household with the participant?</b> (0=No, 1=Yes, 9=Unk)	
<input type="checkbox"/>	<b>How often did you talk with the participant during the prior 11 months?</b> (1=Almost every day, 2=Several times a week, 3=Once a week, 4=1 to 3 times per month, 5=Less than once a month, 9=Unknown)	

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**Mini-mental State Exam**  
**Sentence and Design Handout for Participant**

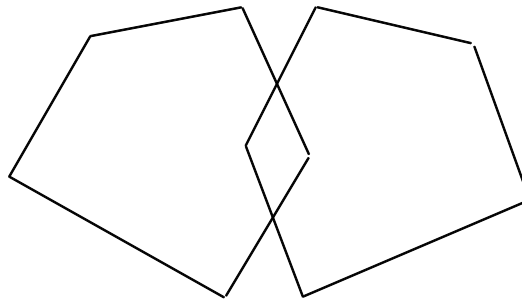
PLEASE WRITE A SENTENCE

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PLEASE COPY THIS DESIGN



OMB No=0925-0216

12/31/2007

**Date of exam**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Framingham Heart Study  
Cohort Exam 29**

**Summary Sheet to Personal Physician**

<b>Blood Pressure</b>	<b>First Reading</b>	<b>Second Reading</b>
<b>Systolic</b>		
<b>Diastolic</b>		

ECG Diagnosis \_\_\_\_\_

\_\_\_\_\_

Summary of Findings \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Examining Physician

*The Heart Study examination is not comprehensive and does not take the place of a routine physical examination.*

### Referral Tracking

OMB No=0925-0216 12/31/2007

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>Physician ID#</b>
<input type="checkbox"/> if yes fill below	Was further medical evaluation recommended for this participant? 0=No, 1=Yes, 9=Unknown
<b>RESULT</b>	<b>Reason for further evaluation:</b> 0=No, 1=Yes, 9=Unknown
<input type="checkbox"/>	<b>Blood Pressure</b> result ____/____ mmHg Phone call > 200/110 Expedite ≥ 180/100 Elevated > 140/90
<i>Write in abnormality</i>	
<input type="checkbox"/>	<b>ECG abnormality</b>
<input type="checkbox"/>	<b>Clinic Physician</b> _____ <b>identified medical problem</b>
<input type="checkbox"/>	<b>Other</b> _____ _____ _____

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>Technician ID#</b>
<input type="checkbox"/>	<b>Was there an adverse event in clinic/offsite exam that does not require further medical evaluation?</b> (0=No, 1=Yes, 9=Unknown) <b>Comments:</b> _____ _____ _____

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>Technician ID#</b> (for offsite visit only)
<input type="checkbox"/>	<b>Was a FHS physician contacted during the examination due to adverse exam findings?</b> (0=No, 1=Yes, 9=Unknown) <b>Comments:</b> _____ _____ _____

OMB No=0925-0216

12/31/2007

<b>Method used to inform participant of need for further medical evaluation</b> (circle ALL that apply)	
<b>1</b>	<b>Face-to-face in clinic</b>
<b>2</b>	<b>Phone call</b>
<b>3</b>	<b>Result letter</b>
<b>4</b>	<b>Other</b>

<b>Method used to inform participant's personal physician of need for further medical evaluation</b> (circle ALL that apply)	
<b>1</b>	<b>Phone call</b>
<b>2</b>	<b>Result letter mailed</b>
<b>3</b>	<b>Result letter FAX'd</b>
<b>4</b>	<b>Other</b>

Date referral made: \_\_\_ -- \_\_\_ -- \_\_\_\_\_

Use 4 digits for year

ID number of person completing the referral: \_\_\_\_\_

Notes documenting conversation with participant or participant's personal physician: \_\_\_\_\_

\_\_\_\_\_

**COHORT EXAM 29**

DATE \_\_\_\_\_

**Medical History--Hospitalizations**

OMB No=0925-0216 12/31/2007

<b>Health Care. Since last Exam or Health Update.</b>	
<input type="checkbox"/>	<b>Examiner prefix</b> (0=MD, 1=Tech)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>Examiner ID</b> _____ <b>Examiner Name</b>
<input type="checkbox"/>	<b>Hospitalization</b> (not just E.R.) since last exam or medical history update (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unknown)
<input type="checkbox"/>	<b>E.R. Visit since last exam or medical history update</b> (0=No; 1=Yes, 1 or more Emergency Room visit, 9=Unknown)
<input type="checkbox"/>	<b>Day Surgery</b> (0=No, 1=Yes, 9=Unknown)
<input type="checkbox"/>	<b>Illness with visit to doctor</b> (0=No, 1=Yes, 1 visit; 2=Yes, more than 1 visit; 9=Unk)
<input type="checkbox"/>	<b>Have you had a fever or infection in past two weeks</b> (0=No, 1=Yes, 9=Unknown)
<input type="checkbox"/>	<b>Check up</b> in interim by doctor (0=No, 1=Yes, 9=Unknown)
_____	<b>Date of this FHS exam</b> (Today's date - See above)
MM DD YYYY	

Medical Encounter	Month/Year (of last visit)	Site of Hospital or Office	Doctor

### Medical History—Medications

OMB No=0925-0216 12/31/2007

#### Hypertension

<input type="text"/>	<p><b>Since your last exam have you taken medication for the treatment of hypertension? (high blood pressure)</b>  <b>(0=No, 1=Yes, now, 2=Yes, not now, 9=Unk)</b></p>
----------------------	---

#### Aspirin use

<input type="text"/> <input type="text"/> <b>If yes,</b>  <input type="text"/> <input type="text"/> <b>fill</b>	<p><b>Take aspirin regularly? (0=No, 1=Yes, 9=Unk)</b></p>
	<p><input type="text"/><input type="text"/> <b>Number aspirins taken regularly (99=Unknown)</b></p>
	<p><input type="text"/> <b>Aspirin frequency- number taken regularly (0=Never, 1=Day, 2=Week 3=Month, 4=Year, 9=Unk)</b></p>
	<p><input type="text"/><input type="text"/><input type="text"/> <b>Usual aspirin dose for above 081=baby,160=half dose, 325=nl, 500=extra or larger,999=unk</b></p>



**Continue from screen 3**

**Medical History— Prescription and Non-Prescription Medications**

OMB NO=0925-0216 12/31/2007

*Copy the name of medicine, the strength including units, and the total number of doses per day/week/month. Include pills, skin patches, eye drops, creams, salves, injections. Include herbal, alternative, and soy-based preparations.*

Medication Name (Print first 20 letters)	Strength (include mg, IU, etc)	Number per (day/week/month) (circle one)	Prn (0=no, 1=yes, 9=unkn)
EXAMPLE:   S   A   M   P   L   E     D   R   U   G     N   A   M   E	100 mg	1	D W M 0
			D W M
			D W M
			D W M
			D W M
			D W M
			D W M
			D W M
			D W M
			D W M
			D W M
			D W M
			D W M
			D W M
			D W M
			D W M

**Blood Pressure**  
(first reading)

*For clinic and offsite visits Examiner ID# equals Examiner ID# in Health Care section.*

Systolic	Diastolic	BP cuff size	Protocol modification
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unknown	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unknown	<input type="text"/> 0=pedi, 1=reg. adult, 2=large adult, 3= thigh, 9=unknown	<input type="text"/> 0=No, 1=Yes, 9=Unknown write in _____

### Medical History–Prostate and Thyroid Disease, Smoking

OMB No=0925-0216 12/31/2007

#### Prostate Disease

**Prostate trouble since your last exam**

0=No,  
1=Yes,  
2=Maybe,  
8=Woman,  
9=Unknown

**Prostate surgery since your last exam**

#### Thyroid

**Since your last exam have you had a diagnosis of a thyroid condition?**  
Comments \_\_\_\_\_  
\_\_\_\_\_

0=No,  
1=Yes,  
9=Unknown

#### Smoking

**Have you smoked cigarettes regularly since your last exam?**

0=No,  
1=Yes, now,  
2=Yes, not now,  
9=Unknown

if yes fill  
☞

**How many cigarettes do/did you smoke a day?**  
(01=one or less, 99=unknown)

### Medical History –Alcohol Consumption.

OMB NO=0925-0216 12/31/2007

<b>Do you drink any of the following beverages at least once a month?</b> (0=no, 1=yes, 9=unknown)		
<input type="checkbox"/>		Beer
<input type="checkbox"/>		Wine
<input type="checkbox"/>		Liquor/spirits
<input type="checkbox"/>		Other
<b>What is your average number of servings in a typical week or month since your last exam ?</b> (999=Unknown) <i>Code alcohol intake as EITHER weekly OR monthly as appropriate.</i>		
Beverage	Per week	Per month
<b>Beer</b> (12oz bottle, glass, can)		_ _ _
<b>Wine</b> (red or white, 4oz glass)	_ _ _	_ _ _
<b>Liquor/spirits</b> (1oz cocktail/highball)	_ _ _	_ _ _
<b>Other</b>	_ _ _	_ _ _

### Medical History—Respiratory Symptoms. Part I

OMB No=0925-0216

12/31/2007

<b>Cough</b>		
<input type="checkbox"/>	<b>Do you usually have a cough?</b> (Exclude clearing the throat)	0=No 1=Yes 9=Don't know
<input type="checkbox"/>	<b>Do you usually have a cough at all on getting up or first thing in the morning?</b>	9=Don't know
If <b>YES</b> to <b>either</b> question above <b>answer</b> the following:		
<input type="checkbox"/>	Do you cough like this on most days for three consecutive months or more during the past year?	0=No 1=Yes 9=Don't know
<input type="checkbox"/>	How many years have you had this cough? (99=Unk.)	# of years
<b>Phlegm</b>		
<input type="checkbox"/>	<b>Do you usually bring up phlegm from your chest apart from colds?</b>	0=No 1=Yes 9=Don't know
<input type="checkbox"/>	<b>Do you usually bring up phlegm at all on getting up or first thing in the morning?</b>	9=Don't know
If <b>YES</b> to <b>either</b> question above <b>answer</b> the following:		
<input type="checkbox"/>	Do you bring up phlegm from your chest on most days (4 or more days/week) for three consecutive months or more during the past year?	0=No 1=Yes 9=Don't know
<input type="checkbox"/>	How many years have you brought phlegm up from your chest on most days? (99=Unk.)	# of years
<b>Wheeze</b>		
<input type="checkbox"/>	<b>In the last 12 months, have you had wheezing or whistling in your chest at any time?</b>	0=No 1=Yes 9=Don't know
if yes, fill all	<input type="checkbox"/> <b>In the last 12 months, how often have you had this wheezing or whistling?</b>	0=Not at all 1=Most days or nights 2=A few days or nights a week 3=A few days or nights a month 4=A few days or nights a year 9=Unknown
<input type="checkbox"/>	<b>In the past 12 months, have you had this wheezing or whistling in the chest when you did NOT HAVE A COLD?</b>	0=No 1=Yes 9=Don't know
<input type="checkbox"/>	<b>In the last 12 months, have you had an attack of wheezing or whistling in the chest that had made you feel short of breath?</b>	9=Don't know

## Medical History—Respiratory Symptoms. Part II

OMB No=0925-0216

12/31/2007

Nocturnal chest symptoms	
<input type="checkbox"/>	<b>In the last 12 months, have you been awakened by shortness of breath?</b>
<input type="checkbox"/>	<b>In the last 12 months, have you been awakened by a wheezing/whistling in your chest?</b>
<input type="checkbox"/>	<b>In the last 12 months, have you been awakened by coughing?</b>
if yes, fill all	<input type="checkbox"/> In the last 12 months, how often have you been awakened by coughing? <div style="float: right; font-size: small; margin-top: 5px;">                     0=Not at all      9=Unknown                      1=Most days or nights                      2=A few days or nights a week                      3=A few days or nights a month                      4=A few days or nights a year                 </div>
Shortness of breath	
<input type="checkbox"/>	<b>Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?</b>
if yes, fill all	<input type="checkbox"/> Do you have to walk slower than people of your age on level ground because of shortness of breath? <input type="checkbox"/> Do you ever have to stop for breath when walking at your own pace on level ground? <input type="checkbox"/> Do you ever have to stop for breath after walking 100 yards (or after a few minutes) on level ground? <div style="float: right; font-size: small; margin-top: 5px;">                     0=No                      1=Yes                      9=Don't know                 </div>
<input type="checkbox"/>	<b>Do you/have you needed to sleep on two or more pillows to help you breathe? (Orthopnea)</b>
<input type="checkbox"/>	<b>Have you since your last exam had swelling in both your ankles (ankle edema)?</b>
<input type="checkbox"/>	<b>Have you since your last exam been told you had heart failure or congestive heart failure?</b>
<input type="checkbox"/>	<b>Have you since your last exam been hospitalized for heart failure?</b>
Examiner's opinion:	
<input type="checkbox"/>	<b>First examiner believes CHF</b>

Comments \_\_\_\_\_

### Medical History-- Heart

OMB No=0925-0216 12/31/2007

<input type="checkbox"/> if yes, fill and below	<input type="checkbox"/> <b>Any chest discomfort since last exam or medical history update?</b> (0=No, 1=Yes, 2=Maybe, 9=Unknown) (please provide narrative comments in addition to checking the appropriate boxes)	
	<input type="checkbox"/>	Chest discomfort with exertion or excitement (0=No, 1=Yes, 2=Maybe, 9=Unknown)
	<input type="checkbox"/>	Chest discomfort when quiet or resting
<b>Chest Discomfort Characteristics</b> (must have checked box at top of table)		
<input type="checkbox"/>	<input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of onset	mo/yr, 99/9999=Unknown
<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Usual duration	(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)
<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Longest duration	(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)
<input type="checkbox"/>	Location	(0=No, 1=Central sternum and upper chest, 2=L up per Quadrant, 3=L lower ribcage, 4=R chest, 5=Other, 6=Combination, 9=Unknown)
<input type="checkbox"/>	Radiation	(0=No, 1=Left shoulder or L arm, 2=Neck, 3=R shoulder or arm, 4=Back, 5=Abdomen, 6=Other, 7=Combination, 9=Unknown)
<input type="checkbox"/>	Frequency (number in past month)	999=Unknown
<input type="checkbox"/>	Frequency (number in past year)	999=Unknown
<input type="checkbox"/>	Type	(1=Pressure, heavy, vise, 2=Sharp, 3=Dull, 4=Other, 9=Unk)
<input type="checkbox"/>	Relief by Nitroglycerine in <15 minutes	0=No
<input type="checkbox"/>	Relief by Rest in <15 minutes	1=Yes,
<input type="checkbox"/>	Relief Spontaneously in <15 minutes	8=Not tried
<input type="checkbox"/>	Relief by Other cause in <15 minutes	9=Unknown

<input type="checkbox"/>	<b>Since your last exam, have you been told by a doctor you had a heart attack?</b> 0=No, 1=Yes, 2=Maybe, 9=Unknown
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CHD First Opinions	
<input type="checkbox"/>	Angina pectoris in interim
<input type="checkbox"/>	Angina pectoris since revascularization procedure
<input type="checkbox"/>	Coronary insufficiency in interim
<input type="checkbox"/>	Myocardial infarct in interim
	0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments \_\_\_\_\_

### Medical History—Atrial Fibrillation/Syncope

OMB No=0925-0216 12/31/2007

<input type="checkbox"/>	<b>Have you been told you have/had a heart rhythm problem called atrial fibrillation?</b> (0=No, 1=Yes, 2=Maybe,, 9=Unknown)																																																							
<b>if yes, fill</b>	<table border="0"> <tr> <td><input type="text"/></td><td><input type="text"/></td><td>*</td><td><input type="text"/></td><td><input type="text"/></td><td>*</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> <td>Date of first episode (99/99/9999=unk) code year as 4 digits, example: Year 1999=1999</td> </tr> <tr> <td><input type="text"/></td><td><input type="text"/></td><td></td><td><input type="text"/></td><td><input type="text"/></td><td></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> <td>mm dd yyyy</td> </tr> <tr> <td></td><td><input type="text"/></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn)</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>Hospitalized at: _____</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>M.D. seen: _____</td> </tr> </table>	<input type="text"/>	<input type="text"/>	*	<input type="text"/>	<input type="text"/>	*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Date of first episode (99/99/9999=unk) code year as 4 digits, example: Year 1999=1999	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	mm dd yyyy		<input type="text"/>									ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn)											Hospitalized at: _____											M.D. seen: _____
<input type="text"/>	<input type="text"/>	*	<input type="text"/>	<input type="text"/>	*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Date of first episode (99/99/9999=unk) code year as 4 digits, example: Year 1999=1999																																														
<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	mm dd yyyy																																														
	<input type="text"/>									ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn)																																														
										Hospitalized at: _____																																														
										M.D. seen: _____																																														

<input type="checkbox"/>	<b>Have you fainted or lost consciousness since your last exam?</b> (If due to stroke skip to screen 11) If event immediately preceded by head injury, or accident code 0=No	Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
<b>if yes, fill all</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Number of episodes in the past two years (999=Unknown)
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> *	Date of first episode (use 4 digits for year, i.e. 1998) (mo/yr, 99/9999=Unknown)
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Usual duration of loss of consciousness (minutes, 999=Unkn)
<b>if yes, fill</b>	<input type="checkbox"/>	Did you have any injury caused by the event? (0=No, 1=Yes, 2=Maybe, 9=Unkn)
	<input type="checkbox"/>	ER/hospitalized or saw M.D. (0=No, 1=ER/Hosp., 2=Saw M.D., 9=Unkn)
		Hospitalized at: _____
		M.D. seen: _____

Syncope First Opinions		
<input type="checkbox"/>	<b>Syncope</b> (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unknown)	
<input type="checkbox"/>	<b>Cardiac syncope</b>	0=No, 1=Yes,
<input type="checkbox"/>	<b>Vasovagal syncope</b>	2=Maybe,
<input type="checkbox"/>	<b>Other-Specify:</b> _____	9=Unknown
<input type="checkbox"/>	<b>Seizure Disorder</b> (0=No, 1=Yes, 2=Maybe,, 9=Unknown)	

Comments

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## Medical History—Cerebrovascular Disease

OMB No=0925-0216 12/31/2007

Cerebrovascular Episodes in Interim	
<input type="checkbox"/>	<b>Sudden muscular weakness</b>
<input type="checkbox"/>	<b>Sudden speech difficulty</b>
<input type="checkbox"/>	<b>Sudden visual defect</b>
<input type="checkbox"/>	<b>Double vision</b>
<input type="checkbox"/>	<b>Loss of vision in one eye</b>
<input type="checkbox"/>	<b>Unconsciousness</b>
<input type="checkbox"/>	<b>Numbness, tingling</b>
<b>if yes, fill</b> ☞	<input type="checkbox"/> Numbness and tingling is positional <input type="checkbox"/>
<input type="checkbox"/>	<b>Head CT or MRI scan since last exam</b> (date/place _____) (0=No, 1=CT, 2=MRI, 3=both, 9=Unknown)
<input type="checkbox"/>	<b>Seen by neurologist</b> (write in who and when below)
<input type="checkbox"/>	<b>Have you been told by a doctor you had a stroke or TIA (transient ischemic attack, mini-stroke)?</b>
<input type="checkbox"/>	<b>Have you been told by a doctor you have Parkinson Disease?</b>
<input type="checkbox"/>	<b>Have you been told by a doctor you have memory problems, dementia or Alzheimer's disease?</b>
<input type="checkbox"/>	<b>Do you feel or do other people think that you have memory problems that prevent you from doing things you've done in the past?</b>
Details for "Serious" Cerebrovascular Event in Interim	
<input type="checkbox"/>	<b>Examiner's opinion that TIA or stroke took place in interim</b> (0=No, 1=Yes, 2=Maybe, 9=Unknown)
<b>if yes or maybe</b>	<input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Date</b> (mo/yr, 99/9999=Unkn) Observed by _____
<b>fill all to</b> ☞	<input type="checkbox"/> <input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>Duration</b> (use format days/hours/mins, 99/99/99=Unknown)
<input type="checkbox"/>	<b>Hospitalized or saw M.D.</b> (0=No, 1=Hosp.2=Saw M.D, 9=Unk) Name _____ Address _____
Neurology First Opinions	
<input type="checkbox"/>	<b>Stroke in Interim</b>
<input type="checkbox"/>	<b>TIA</b>
<input type="checkbox"/>	<b>Dementia</b>
<input type="checkbox"/>	<b>Parkinson Disease</b>
<input type="checkbox"/>	<b>Other-- Specify:</b> _____

Neurology Comments

### Medical History--Peripheral Arterial Disease

OMB No=0925-0216 12/31/2007

<input type="checkbox"/>	<b>Can you walk 50 feet without help?</b> (0=Able to walk 50 feet without help, 1=Needs help, 2=Can't walk, 9=Unknown)		
<input type="checkbox"/>	<b>Do you have lower limb discomfort while walking?</b> (0=No, 1=Yes, 2=Can't walk, 9=Unknown)		
<b>if yes fill</b>	_ _	<b>If walking on level ground, how many city blocks until symptoms develop</b> (00=no, 99=unknown) where 10 blocks=1 mile, code as no if more than 98 blocks required to develop symptoms	
	_ _ _ _	<b>Year symptoms started</b> ( 9999=unknown)	
<b>if yes fill in below</b>	<b>Left</b>	<b>Right</b>	<b>Vascular symptoms</b>
	_	_	Discomfort in calf while walking
	_	_	Discomfort in lower extremity (not calf) while walking
	_		Occurs with first steps (code worse leg)
	_		After walking a while (code worse leg)
	_		Related to rapidity of walking or steepness
	_		Forced to stop walking
	_ _		Time for discomfort to be relieved by stopping (minutes) (00=No relief with stopping, 88=Not Applicable, 99=Unknown)
	_ _		Number of days/month of lower limb discomfort ( 88=N/A, 99=Unknown)

<input type="checkbox"/>	<b>Have you ever been told by a doctor you have intermittent claudication or peripheral arterial disease ?</b>			0=No, 1=Yes, 9=Unknown
<input type="checkbox"/>	<b>Has a doctor ever told you you had spinal stenosis?</b>			
<b>if yes, fill</b>	_	<b>Have you had a CT or MRI of your spine?</b> Date ___-___-___ Location _____		

PAD First Opinions	
<input type="checkbox"/>	<b>Intermittent Claudication</b>
	0=No, 1=Yes, 2=Maybe, 9=Unknown

**Comments** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Venous Disease and Second Blood Pressure

OMB No=0925-0216 12/31/2007

<b>Venous Disease</b>		
<input type="checkbox"/>	<b>Since your last exam have you had a Deep Vein Thrombosis (blood clots in legs or arms)</b>	0=No, 1=Yes, 9=Unknown
<input type="checkbox"/>	<b>Since your last exam have you had a Pulmonary Embolus (blood clots in lungs)</b>	

<b>Second Blood Pressure</b> (second reading)			
<i>For clinic and offsite visits Examiner ID# equals Examiner ID# in Health Care section</i>			
Systolic	Diastolic	BP cuff size	Protocol modification
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unknown	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unknown	<input type="text"/> 0=pedi, 1=reg. adult, 2=large adult, 3= thigh, 9=unknown	<input type="text"/> 0=No, 1=Yes, 9=Unknown

Comments on Protocol modification

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OMB No=0925-0216

12/31/2007

Coding: 0=No, 1=Yes 2=Maybe, 9=Unkn	<p align="center"><b>Cardiovascular Procedures in Interim</b>                  (if procedure was repeated code only first in interim and provide narrative)                  (write 4 digits for year, i.e. 1998, 1999, 2000)</p>
<input type="checkbox"/> if yes fill	<p align="center"><b>Heart Valvular Surgery (most recent only)</b></p>  __ __ __ __  Year done (9999=Unk) Location and description _____
<input type="checkbox"/> if yes fill	<p align="center"><b>Exercise Tolerance Test (most recent only)</b></p>  __ __ __ __  Year done (9999=Unk) Location _____
<input type="checkbox"/> if yes fill	<p align="center"><b>Coronary arteriogram (most recent only)</b></p>  __ __ __ __  Year done (9999=Unk)
<input type="checkbox"/> if yes fill	<p align="center"><b>Coronary artery angioplasty</b></p>  __ __ __ __  Year done (9999=Unk)  __  Type of procedure (0=none, 1=balloon, 2=stent, 3=other, 9=unkn)
<input type="checkbox"/> if yes fill	<p align="center"><b>Coronary bypass surgery</b></p>  __ __ __ __  Year done (9999=Unk)
<input type="checkbox"/> if yes fill	<p align="center"><b>Permanent pacemaker insertion</b></p>  __ __ __ __  Year done (9999=Unk)
<input type="checkbox"/> if yes fill	<p align="center"><b>Carotid artery surgery</b></p>  __ __ __ __  Year done (9999=Unk)
<input type="checkbox"/> if yes fill	<p align="center"><b>Thoracic aorta surgery</b></p>  __ __ __ __  Year done (9999=Unk)
<input type="checkbox"/> if yes fill	<p align="center"><b>Abdominal aorta surgery</b></p>  __ __ __ __  Year done (9999=Unk)
<input type="checkbox"/> if yes fill	<p align="center"><b>Femoral or lower extremity surgery</b></p>  __ __ __ __  Year done (9999=Unk)
<input type="checkbox"/> if yes fill	<p align="center"><b>Lower extremity amputation</b></p>  __ __ __ __  Year done (9999=Unk)
<input type="checkbox"/> if yes fill	<p align="center"><b>Other Cardiovascular Procedure (write in below)</b></p>  __ __ __ __  Year done (9999=Unk) Description _____

Comments: \_\_\_\_\_

\_\_\_\_\_

### Cancer Site or Type

OMB No=0925-0216

12/31/2007

**Have you, since your last clinic visit or medical history update, had a cancer or a tumor?**  
 0=No - skip to next screen  
 1=Yes, fill in table below, using the following code:  
*Code each "site", putting "0" for all sites having no interim tumor.*  
**1= Definite cancer**  
**2=Tumor, nature unknown**  
**3=Definitely benign**  
**9=Unknown**

Code	Site of Cancer or Tumor	Year First Diagnosed	Name Diagnosing M.D.	City of M.D.
<input type="checkbox"/>	Esophagus			
<input type="checkbox"/>	Stomach			
<input type="checkbox"/>	Colon			
<input type="checkbox"/>	Rectum			
<input type="checkbox"/>	Pancreas			
<input type="checkbox"/>	Larynx			
<input type="checkbox"/>	Trachea/Bronchus/Lung			
<input type="checkbox"/>	Leukemia			
<input type="checkbox"/>	Skin			
<input type="checkbox"/>	Breast			
<input type="checkbox"/>	Cervix/Uterus			
<input type="checkbox"/>	Ovary			
<input type="checkbox"/>	Prostate			
<input type="checkbox"/>	Bladder			
<input type="checkbox"/>	Kidney			
<input type="checkbox"/>	Brain			
<input type="checkbox"/>	Lymphoma			
<input type="checkbox"/>	Other/Unknown			

**Comment** (If participant has more details concerning tissue diagnosis, other hospitalization, procedures, treatments)

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## Electrocardiograph--Part I

OMB No=0925-0216 12/31/2007

<input type="text"/> <input type="text"/> <input type="text"/>	<b>Examiner ID Number</b> _____ <b>Examiner Last Name</b> _____
<input type="checkbox"/> if Yes, fill out rest of form	<b>ECG done (0=No, 1=Yes)</b>
<b>Rates and Intervals</b>	
<input type="text"/>	<b>Ventricular rate per minute</b> (999=Unknown)
<input type="text"/>	<b>P-R Interval (hundredths of a second)</b> (99=Fully Paced, Atrial Fib, or Unknown)
<input type="text"/>	<b>QRS interval (hundredths of second)</b> (99=Fully Paced, Unknown)
<input type="text"/>	<b>Q-T interval (hundredths of second)</b> (99=Fully Paced, Unknown)
<input type="text"/>	<b>QRS angle (put plus or minus as needed)</b> (e.g. -045 for minus 45 degrees, +090 for plus 90, 9999=Fully paced or Unknown)
<b>Rhythm--predominant</b>	
<input type="checkbox"/>	<b>0 or 1 = Normal sinus</b> , (including s.tach, s.brady, s arrhy, 1 degree AV block) <b>3 = 2nd degree AV block, Mobitz I (Wenckebach)</b> <b>4 = 2nd degree AV block, Mobitz II</b> <b>5 = 3rd degree AV block / AV dissociation</b> <b>6 = Atrial fibrillation / atrial flutter</b> <b>7 = Nodal</b> <b>8 = Paced</b> <b>9 = Other or combination of above (list)</b> _____
<b>Ventricular conduction abnormalities</b>	
<input type="checkbox"/> if yes, fill	<b>IV Block</b> (0=No, 1=Yes, 9=Fully paced or Unknown) <input type="checkbox"/> <b>Pattern</b> (1=Left, 2=Right, 3=Indeterminate, 9=Unknown)
<input type="checkbox"/>	<b>Complete (QRS interval=.12 sec or greater)</b> (0=No, 1=Yes, 9=Unknown)
<input type="checkbox"/>	<b>Incomplete (QRS interval = .10 or .11 sec)</b> (0=No, 1=Yes, 9=Unknown)
<input type="checkbox"/>	<b>Hemiblock</b> (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unknown)
<input type="checkbox"/>	<b>WPW Syndrome</b> (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)
<b>Arrhythmias</b>	
<input type="checkbox"/>	<b>Atrial premature beats</b> (0=No, 1=Atr, 2=Atr Aber, 9=Unknown)
<input type="checkbox"/>	<b>Ventricular premature beats</b> (0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)
<input type="text"/>	<b>Number of ventricular premature beats in 10 seconds</b> (see 10 second rhythm strip, 99=Unknown)

## Electrocardiograph-Part II

OMB No=0925-0216 12/31/2007

Myocardial Infarction Location	
<input type="checkbox"/>	Anterior <span style="float: right; font-size: small;">(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)</span>
<input type="checkbox"/>	Inferior
<input type="checkbox"/>	True Posterior
Left Ventricular Hypertrophy Criteria	
<input type="checkbox"/>	R > 20mm in any limb lead <span style="float: right; font-size: small;">(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)</span>
<input type="checkbox"/>	R > 11mm in AVL
<input type="checkbox"/>	R in lead I plus S ≥ 25mm in lead III
Measured Voltage	
* <input type="checkbox"/> <input type="checkbox"/>	R AVL in mm (at 1 mv = 10 mm standard) Be sure to code these voltages
* <input type="checkbox"/> <input type="checkbox"/>	S V3 in mm (at 1 mv = 10 mm standard) Be sure to code these voltages
R in V5 or V6----S in V1 or V2	
<input type="checkbox"/>	R ≥ 25mm
<input type="checkbox"/>	S ≥ 25mm
<input type="checkbox"/>	R or S ≥ 30mm <span style="float: right; font-size: small;">(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)</span>
<input type="checkbox"/>	R + S ≥ 35mm
<input type="checkbox"/>	Intrinsicoid deflection ≥ .05 sec
<input type="checkbox"/>	S-T depression (strain pattern)
Hypertrophy, enlargement, and other ECG Diagnoses	
<input type="checkbox"/>	Nonspecific S-T segment abnormality (0=No, 1=S-T depression, 2=S-T flattening, 3=Other, 9=Fully paced or unknown)
<input type="checkbox"/>	Nonspecific T-wave abnormality (0=No, 1=T inversion, 2=T flattening, 3=Other, 9=Fully paced or unknown)
<input type="checkbox"/>	U-wave present (0=No, 1=Yes, 2=Maybe, 9=Paced or Unknown)
<input type="checkbox"/>	Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unknown)
<input type="checkbox"/>	RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown; If complete RBBB present, RVH=9)
<input type="checkbox"/>	LVH (0=No, 1=LVH with strain, 2=LVH with mild S-T Segment Abn, 3=LVH by voltage only, 9=Fully paced or Unkn, If complete LBBB present, LVH=9)

**Comments and Diagnosis** \_\_\_\_\_

### Clinical Diagnostic Impression.

OMB No=0925-0216

12/31/2007

Non Cardiovascular Diagnoses First Examiner Opinions	
<input type="checkbox"/>	Diabetes Mellitus
<input type="checkbox"/>	Prostate disease
<input type="checkbox"/>	Renal disease (specify) _____
<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Chronic bronchitis
<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Other pulmonary disease
<input type="checkbox"/>	Gout
<input type="checkbox"/>	Degenerative joint disease
<input type="checkbox"/>	Rheumatoid arthritis
<input type="checkbox"/>	Gallbladder disease
<input type="checkbox"/>	Other non C-V diagnosis (for cancer, see special screen)

0=No,  
1=Yes,  
2=Maybe,  
9=Unknown

**Comments CDI Other Diagnoses**

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