

Numerical Data

<input type="checkbox"/>	Check here if whole page is blank. Reason why _____
_ _ _	Technician Number. (for basic information)

Basic Information	
_	Sex of Participant 1=Male, 2=Female
_	Site of Exam (0=Heart Study, 1=Nursing home, 2=Residence, 3=Other).
_ _	Age of Participant (number of years)
_ _	What state do you reside in? (If reside outside the USA, code ZZ, if plans to wear accelerometer while visiting USA code state of visit) Code: AL, AK, AS, etc.

Anthropometry	
<i>Check Protocol Modification ONLY if there was one and document it in Comment section</i>	
88*88=Refused, 99*99=Not done or Unk	
_ _ _	Weight (to nearest pound) (400=400 or more. 888=refused, 999=Unk.)
<input type="checkbox"/>	Protocol modification.
_ _ * _ _	Height (inches, to next lower 1/4 inch)
<input type="checkbox"/>	Protocol modification.
_ _ _	Technician Number. (for anthropometry)
_ _ * _ _	Neck Circumference (inches, to next lower 1/4 inch)
<input type="checkbox"/>	Protocol modification.
_ _ * _ _	Waist Girth at umbilicus (inches, to next lower 1/4 inch).
<input type="checkbox"/>	Protocol modification.
_ _ * _ _	Hip Girth (inches, to next lower 1/4 inch)
<input type="checkbox"/>	Protocol modification
_ _ * _ _	Thigh Girth (inches, to next lower 1/4 inch)
<input type="checkbox"/>	Protocol modification.
_ _ * _	Sagittal abdominal diameter (to nearest 0.1 cm) (36.0=36.0 or more)
<input type="checkbox"/>	Protocol modification.

Comments for ALL Protocol Modification (specify measurement)

TECH01

Check here if whole page is blank. Reason why _____

Gen3 Exam 2 Procedures Sheet

0=No, 1=Yes, 8=Offsite visit

<input type="checkbox"/>	Type of Exam	1=Complete exam, 2=Split exam(exam completed in 2 visits), 3=short exam (incomplete exam)
<input type="checkbox"/>	Informed Consent Signed	0=No, 1=Yes, 2=Consent by substituted judgment
<input type="checkbox"/>	Urine Specimen	
<input type="checkbox"/>	Blood Draw	
<input type="checkbox"/>	Glucose tolerance test	
<input type="checkbox"/>	Anthropometry	
<input type="checkbox"/>	Sociodemographic Questions	
<input type="checkbox"/>	SF-12 Health Survey	
<input type="checkbox"/>	Harvard University Dietary Assessment (FFQ)	
<input type="checkbox"/>	CES-D Scale	
<input type="checkbox"/>	Exercise Questionnaire	
<input type="checkbox"/>	Neurocognitive Questionnaire (CERAD, Victoria Stroop)	
<input type="checkbox"/>	ECG	
<input type="checkbox"/>	P Wave Signal Averaged ECG	
<input type="checkbox"/>	Observed performance (Fast walk, hand grip, chair stands)	
<input type="checkbox"/>	Tonometry	
<input type="checkbox"/>	Ankle-brachial blood pressure by Doppler. (Participants \geq 40 years)	
<input type="checkbox"/>	Spirometry	0=Not Done, 1=Done, 2=Test attempted but not finished, 8=Offsite
<input type="checkbox"/>	Reason Spirometry not done	1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted by tech, 8=Other, 10=equipment problems
<input type="checkbox"/>	Post albuterol Spirometry (sub-sample)	0=Not Done, 1=Done, 2=Test attempted but not finished, 8=Offsite
<input type="checkbox"/>	Reason post bronchodilator test not done	1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted by tech, 8=Other, 10=equipment problems, 11=didn't qualify for test
<input type="checkbox"/>	Diffusion Capacity	0=Not Done, 1=Done, 2=Test attempted but not finished, 8=Offsite
<input type="checkbox"/>	Reason Diffusion not done	1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted by tech, 8=Other, 10=equipment problems
<input type="checkbox"/>	Accelerometer	

TECH02

For Participants Who Wish to Complete Their Exam on a Second Visit (Split Exam)

<input type="text"/>	Second Exam Date (If participant returns to finish their clinic exam on a date other than the original exam date, then fill in the date they return here. Otherwise leave entire page completely blank)
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Keyers: if Second Exam Date is not filled and page is blank' then leave the page all blank.

Fill in with 1=yes if procedure **was done** on the **Second** Exam Date and 0=no if procedure **was not done** on the **Second** Exam Date. Note that informed consent from first visit will cover the second visit.

Gen3 Exam 2 Procedures Sheet	
0=No, 1=Yes, 8=Offsite visit	
<input type="checkbox"/>	Urine Specimen
<input type="checkbox"/>	Blood Draw
<input type="checkbox"/>	Glucose tolerance test
<input type="checkbox"/>	Anthropometry
<input type="checkbox"/>	Sociodemographic Questions
<input type="checkbox"/>	SF-12 Health Survey
<input type="checkbox"/>	Harvard University Dietary Assessment (FFQ)
<input type="checkbox"/>	CES-D Scale
<input type="checkbox"/>	Exercise Questionnaire
<input type="checkbox"/>	Neurocognitive Questionnaire (CERAD, Victoria Stroop)
<input type="checkbox"/>	ECG
<input type="checkbox"/>	Signal Averaged ECG
<input type="checkbox"/>	Observed performance (Fast walk, hand grip, chair stands)
<input type="checkbox"/>	Tonometry
<input type="checkbox"/>	Ankle-brachial blood pressure by Doppler. (Participants \geq 40 years)
<input type="checkbox"/>	Spirometry 0=Not Done, 1=Done, 2=Test attempted but not finished, 8=Offsite
<input type="checkbox"/>	Reason Spirometry not done 1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted by tech, 8=Other, 10=equipment problems
<input type="checkbox"/>	Post albuterol Spirometry (sub-sample) 0=Not Done, 1=Done, 2=Test attempted but not finished, 8=Offsite
<input type="checkbox"/>	Reason post bronchodilator test not done 1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted by tech, 8=Other, 10=equipment problems, 11=didn't qualify for test
<input type="checkbox"/>	Diffusion Capacity 0=Not Done, 1=Done, 2=Test attempted but not finished, 8=Offsite
<input type="checkbox"/>	Reason Diffusion not done 1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP>210/110, 6=Refused, 7=Test Aborted by tech, 8=Other, 10=equipment problems
<input type="checkbox"/>	Accelerometer

TECH03

Ankle Brachial Blood Pressure Measurements. Participants ≥ 40 years

SYSTOLIC BLOOD PRESSURES BY DOPPLER (to be taken in the following order with participant supine after 5 minutes of rest)

<input type="checkbox"/>	Page blank and Participant <40	<input type="checkbox"/>	Page blank and Participant ≥ 40 ; fill	Reason why _____
_ _ _		Technician Number for Doppler Ankle Brachial Blood Pressure.		
_	Cuff size, arm	0= pediatric, 1= regular adult		
_	Cuff size, ankle	2= large adult, 3= thigh		

_ _ _	Right arm	
_ _ _	Right ankle	300= \geq 300 mmHg
_ _ _	Left ankle	888= Not Done
_ _ _	Left arm	999= Unk.

REPEAT SYSTOLIC BLOOD PRESSURE MEASUREMENTS (reverse order)

_ _ _	Left arm	
_ _ _	Left ankle	300= \geq 300 mmHg
_ _ _	Right ankle	888= Not Done
_ _ _	Right arm	999= Unk.

THIRD SYSTOLIC BLOOD PRESSURE MEASUREMENT (order as in repeat SBP). To be obtained if initial and repeat SBP at any site differ by more than 10 mmHg. For site that differs.

_ _ _	Right arm	
_ _ _	Right ankle	300= \geq 300 mmHg
_ _ _	Left ankle	888= Not Done
_ _ _	Left arm	999= Unk.

_	Right Ankle blood pressure site	0= posterior tibial (ankle)
_	Left Ankle blood pressure site	1= dorsalis pedis (foot)

EXCLUSIONS:

Enter exclusion **ONLY** if there is an 888 above.

Right	Left	
_	_	Lower Extremity Exclusions 1= venous stasis ulceration, 2= amputation, 3= other _____
_	_	Upper Extremity Exclusions 1=Mastectomy, 3= Other _____
<input type="checkbox"/> Check if Protocol modification, write in _____		
Comments _____		

TECH04

Check here if whole page is blank. Reason why _____

Exit Interview

Technician Number

Procedure sheet reviewed

Referral sheet reviewed

0=No

Dietary questionnaire provided (if not completed in clinic)

1=Yes

Left clinic with accelerometer

9=Unk.

Left clinic w/ belongings

Chest and Abdominal CT test brochure given 8=*not asked or not eligible*

Feedback 0=No feedback, 1=Positive feedback, 2=Negative feedback, 3=Other, 9=Unk.

Comments _____

Technician Number

Was there an adverse event in clinic that does not require further medical evaluation?
(0=No, 1=Yes, 9=Unk.)

Comments: _____

Technician who reviewed TECH portion of exam

Your exam today was for research purposes only and is not designed to make a medical diagnosis. The exam cannot identify all serious heart and health issues. It is important that you continue regular follow-up with your physician or health care provider.

TECH05

Respiratory Disease Questionnaire, Part 1 Technician Administered.

Check here if whole page is blank. Reason why _____

Respiratory Diagnoses

____ Technician Number

Since your last exam.... (0=No, 1=Yes, 9=Unk.)

Have you had asthma?

If yes,
fill 

Do you still have it?

Was it diagnosed by a doctor or other health care professional?

If it started since your last exam, at what age did it start? (Age in years) If it started before last exam enter 88=N/A, 99=Unk.

If you no longer have it, at what age did it stop? (Age in years) 88=still have it, 99=Unk.

Have you received medical treatment for this in the past 12 months?

Have you had hay fever (allergy involving the nose and/or eyes)?

Have you had any of the following conditions diagnosed by a doctor or other health care professional?
(0=No, 1=Yes, 9=Unk.)

Chronic Bronchitis

Emphysema

COPD (Chronic obstructive pulmonary disease)

Sleep Apnea

Pulmonary Fibrosis

Inhaler Use

(0=No, 1=Yes)

Do you take inhalers or bronchodilators?

If yes,
fill 

Do you use any of these medications- albuterol, Atrovent, Proventil, Ventolin, Combivent, Maxair, Volmax, Xopenex, Bronkometer, Pro-Air, pirbuterol, levalbuterol, metaproterenol, or ipratropium

If yes,
fill 

How many hours ago did you last use the medication, either by inhaler or nebulizer?

**Time in
hours 1-48**

if last used >48 hrs ago code 88, 99= Unk.

Do you take any of the following inhalers? Serevent, Advair, Foradil, salmeterol, formoterol, Spiriva, Symbicort, Brovana, arformoterol, or tiotropium

If yes,
fill 

How many hours ago did you last use the medication?
if last used >48 hrs ago code 88, 99=Unk.

**Time in
hours 1-48**

TECH06

Respiratory Disease Questionnaire, Part 2.
Technician Administered.

Check here if whole page is blank. Reason why _____

Triggered airway symptoms

(0=No, 1=Yes, 9=Unk.)

When you are near animals, such as cats, dogs, or horses, near feathers, including pillows, quilts, or in a dusty or moldy part of the house, do you ever...

- Start to cough?
- Start to wheeze?
- Get a feeling of tightness in your chest?
- Start to feel short of breath?
- Get a runny or stuffy nose or start to sneeze?
- Get itching or watering eyes?

When you are near trees, grass, or flowers, or when there is a lot of pollen in the air, do you ever...

- Start to cough?
- Start to wheeze?
- Get a feeling of tightness in your chest?
- Start to feel short of breath?
- Get a runny or stuffy nose or start to sneeze?
- Get itching or watering eyes?

TECH07

Sociodemographic questions. Part I

Self-administered

What is your current marital status? (check ONE)	
<input type="checkbox"/>	1 single/never married
<input type="checkbox"/>	2 married/living as married/living with partner
<input type="checkbox"/>	3 separated
<input type="checkbox"/>	4 divorced
<input type="checkbox"/>	5 widowed
<input type="checkbox"/>	9 prefer not to answer
Which of the following best describes you?	
Ethnicity (check ONE)	
<input type="checkbox"/>	1 Hispanic or Latino
<input type="checkbox"/>	2 Not Hispanic or Latino
Race: (check ALL that apply)	
<input type="checkbox"/>	Caucasian or White
<input type="checkbox"/>	African-American or Black
<input type="checkbox"/>	Asian
<input type="checkbox"/>	Native Hawaiian or other Pacific Islander
<input type="checkbox"/>	American Indian or Alaska native
<input type="checkbox"/>	prefer not to answer
What is the HIGHEST degree or level of school you have completed? (if currently enrolled, mark the highest grade completed, degree received) (check ONE)	
<input type="checkbox"/>	0 no schooling
<input type="checkbox"/>	1 grades 1-8
<input type="checkbox"/>	2 grades 9-11
<input type="checkbox"/>	3 completed high school (12 th grade) or GED
<input type="checkbox"/>	4 some college but no degree
<input type="checkbox"/>	5 technical school certificate
<input type="checkbox"/>	6 associate degree (Junior college AA, AS)
<input type="checkbox"/>	7 Bachelor's degree (BA, AB, BS)
<input type="checkbox"/>	8 graduate or professional degree (master's, doctorate, MD, etc.)
<input type="checkbox"/>	9 prefer not to answer
Please choose which of the following best describes your current employment status? (check ONE)	
<input type="checkbox"/>	0 homemaker, not working outside the home
<input type="checkbox"/>	1 employed (or self-employed) full time
<input type="checkbox"/>	2 employed (or self-employed) part time
<input type="checkbox"/>	3 employed, but on leave for health reasons
<input type="checkbox"/>	4 employed, but temporarily away from my job
<input type="checkbox"/>	5 unemployed or laid off
<input type="checkbox"/>	6 retired from my usual occupation and not working
<input type="checkbox"/>	7 retired from my usual occupation but working for pay
<input type="checkbox"/>	8 retired from my usual occupation but volunteering
<input type="checkbox"/>	9 prefer not to answer
<input type="checkbox"/>	10 unemployed due to disability
<input type="checkbox"/>	11 full-time student

TECH08

Sociodemographic questions. Part II.
Self-administered

What is your current occupation? Write in _____

||| Using the occupation coding sheet choose the code that best describes your occupation.

Please select income group that best represents your combined family income for the past 12 months.
(check ONE)

- 1 under \$20,000
- 2 \$20,000 – \$34,999
- 3 \$35,000 – \$54,999
- 4 \$55,000 – \$74,999
- 5 \$75,000 – \$100,000
- 6 over \$100,000
- 9 prefer not to answer

||| **How many people are supported by this income?**

What form of health insurance do you have currently? (check ALL that apply)

- HMO or other private insurance such as Blue Cross, Aetna, Harvard-Pilgrim, etc
- Medicare
- Medicaid
- Military or Veteran's administration sponsored
- Other

YES **NO** **Do you have prescription drug coverage?** (check ONE)

TECH09

SF-12® Health Survey (Standard) Self-administered

This questionnaire asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by marking one box. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
4. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
5. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
6. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
7. Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>

TECH10

SF-12® Health Survey (Standard)
Self-administered

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TECH11

Simplified nutritional appetite questionnaire (SNAQ)

Self-administered

Please check **ONE** box **FOR EACH** question in the following table

My appetite is	
<input type="checkbox"/>	1 very poor
<input type="checkbox"/>	2 poor
<input type="checkbox"/>	3 average
<input type="checkbox"/>	4 good
<input type="checkbox"/>	5 very good
When I eat	
<input type="checkbox"/>	1 I feel full after eating only a few mouthfuls
<input type="checkbox"/>	2 I feel full after eating about a third of a meal
<input type="checkbox"/>	3 I feel full after eating over half a meal
<input type="checkbox"/>	4 I feel full after eating most of the meal
<input type="checkbox"/>	5 I hardly ever feel full
Food tastes	
<input type="checkbox"/>	1 very bad
<input type="checkbox"/>	2 bad
<input type="checkbox"/>	3 average
<input type="checkbox"/>	4 good
<input type="checkbox"/>	5 very good
Normally I eat	
<input type="checkbox"/>	1 less than one meal a day
<input type="checkbox"/>	2 one meal a day
<input type="checkbox"/>	3 two meals a day
<input type="checkbox"/>	4 three meals a day
<input type="checkbox"/>	5 more than three meals a day

YES	NO	Questions about eating
<input type="checkbox"/>	<input type="checkbox"/>	Do you often feel that you can't control <u>what</u> or <u>how much</u> you eat?
<input type="checkbox"/>	<input type="checkbox"/>	Do you often eat, <u>within any 2-hour period</u>, what most people would regard as an unusually <u>large</u> amount of food?
If you checked 'YES' to either questions above, please answer next question		
How often has this occurred, on average, over the last 6 months? (Check ONE)		
1 <input type="checkbox"/>	less than once per month	3 <input type="checkbox"/> 2-3 times per month
2 <input type="checkbox"/>	once per month	4 <input type="checkbox"/> once per week
		5 <input type="checkbox"/> twice per week or more

TECH12

CES-D Scale Tech-administered

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
_ _ _	Technician Number	

The questions below ask about your feelings. For each statement, please say how often you felt that way during the past week.

DURING THE PAST WEEK	Circle best answer for each question			
	<u>Rarely</u> or none of the time (less than 1 day)	<u>Some</u> or a little of the time (1-2 days)	<u>Occasionally</u> or moderate amount of time (3-4 days)	<u>Most</u> or all of the time (5-7 days)
*I was bothered by things that usually don't bother me.	0	1	2	3
I did not feel like eating; my appetite was poor.	0	1	2	3
I felt that I could not shake off the blues, even with help from my family and friends.	0	1	2	3
I felt that I was just as good as other people.	0	1	2	3
I had trouble keeping my mind on what I was doing.	0	1	2	3
*I felt depressed.	0	1	2	3
I felt that everything I did was an effort.	0	1	2	3
I felt hopeful about the future.	0	1	2	3
I thought my life had been a failure.	0	1	2	3
I felt fearful.	0	1	2	3
*My sleep was restless.	0	1	2	3
I was happy.	0	1	2	3
I talked less than usual.	0	1	2	3
I felt lonely.	0	1	2	3
People were unfriendly.	0	1	2	3
I enjoyed life.	0	1	2	3
I had crying spells.	0	1	2	3
I felt sad.	0	1	2	3
I felt that people disliked me	0	1	2	3
I could not "get going"	0	1	2	3

* Indicates that the technician should preface the statement with "During the past week"

TECH13

Rosow-Breslau and Fractures Questionnaire.

Tech-administered

Check here if whole page is blank. Reason why _____

____ Technician Number

Rosow-Breslau Questions

- | | | |
|---|---|-------------------------|
| _ | Are you able to do heavy work around the house, like shoveling snow or washing windows, walls, or floors without help? | 0=No
1=Yes
9=Unk. |
| _ | Are you able to walk half a mile without help? (About 4-6 blocks) | |
| _ | Are you able to walk up and down one flight of stairs without help? | |

Fractures

|_| **Since Your Last Clinic Visit Have You Broken Any Bones?**
(0=No, 1=Yes, 2=Maybe, 9=Unk.)

If Yes, fill

- | | |
|---|--|
| _ _ | Location of fracture: |
| _ _ | Location of second fracture (if more than one): |
| _ _ | Location of third fracture (if more than two): |
| Code for Location (<i>code Unk. as 99</i>) | |
| 1= Clavicle (collar bone) | |
| 2=Upper arm (humerus) or elbow | |
| 3=Forearm or wrist | |
| 4=Hand | |
| 5=Back (<i>If disc disease only, code as no</i>) | |
| 6=Pelvis | |
| 7=Hip | |
| 8=Leg | |
| 9=Foot | |
| 10=Other, specify _____ | |

TECH14

Physical Activity Questionnaire--Framingham Heart Study, Part 1
Tech-administered

Check here if whole page is blank. Reason why _____

____ Technician Number

Rest and Activity for a Typical Day over the past year. (A typical day = most days of the week) (Activities must equal 24 hours)	Number of hours
Sleep --Number of hours that you typically sleep?	_ _
Sedentary --Number of hours typically sitting?	_ _
Slight Activity --Number of hours with activities such as standing, walking?	_ _
Moderate Activity --Number of hours with activities such as housework (vacuum, dust, yard chores, climbing stairs; light sports such as bowling, golf)?	_ _
Heavy Activity --Number of hours with activities such as heavy household work, heavy yard work such as stacking or chopping wood, exercise such as intensive sports--jogging, swimming etc.?	_ _
Total number of hours (should be the total of above items)	24

Comments _____

TECH15

Physical Activity Questionnaire--Framingham Heart Study. Part 2

Tech-administered

Check here if whole page is blank. Reason why _____

____| **Technician Number**

Now I'll ask you about your Physical Activities. Only include the time spent actually doing the activity. For example, sitting by the pool does not count as time swimming; sitting in a chair lift does not count for skiing.

First I'll ask about **vigorous activities**. Vigorous activities increase your heart rate, or make you sweat doing them, or make you breathe hard, or raise your body temperature. If you do an activity but not vigorously, please include it later when I ask you about other non-strenuous activities.

For all estimates, round up to nearest whole number.

In the past 12 months for at least one hour total time in any month did you do the following activities. For example you may have done three 20 minute sessions in the month.

_	Jog or run?		0=No, 1=Yes
if yes, fill ☞	_ _	How many months did you do this activity?	99=Unk.
	_ _	How many times per month did you do this activity?	99=Unk
	_ _ _	How long did you do this activity on average each time? (# of minutes)	999=Unk

_	Do vigorous racket sports?		0=No, 1=Yes
if yes, fill ☞	_ _	How many months did you do this activity?	99=Unk
	_ _	How many times per month did you do this activity?	99=Unk
	_ _ _	How long did you do this activity on average each time? (# of minutes)	999=Unk

_	Bicycle faster than 10 miles/hour or exercise hard on an exercise bicycle or any other machine such as elliptical trainer, Stairmaster, etc.?		0=No, 1=Yes
if yes, fill ☞	_ _	How many months did you do this activity?	99=Unk
	_ _	How many times per month did you do this activity?	99=Unk
	_ _ _	How long did you do this activity on average each time? (# of minutes)	999=Unk

_	Swim?		0=No, 1=Yes
if yes, fill ☞	_ _	How many months did you do this activity?	99=Unk
	_ _	How many times per month did you do this activity?	99=Unk
	_ _ _	How long did you do this activity on average each time? (# of minutes)	999=Unk

TECH16

Physical Activity Questionnaire--Framingham Heart Study, Part 3

Tech-administered

Check here if whole page is blank. Reason why _____

In the past 12 months for at least one hour total time in any month did you...

_	Do a vigorous exercise class or vigorous dancing?	0=No, 1=Yes
if yes, fill ☞	_ _ How many months did you do this activity?	99=Unk
	_ _ How many times per month did you do this activity?	99=Unk
	_ _ _ How long did you do this activity on average each time? (# of minutes)	999=Unk

_	Do any vigorous job activities such as lifting, carrying, or digging?	0=No, 1=Yes
if yes, fill ☞	_ _ How many months did you do this activity?	99=Unk
	_ _ How many times per month did you do this activity?	99=Unk
	_ _ _ How long did you do this activity on average each time? (# of minutes)	999=Unk

_	Do any home activities such as snow shoveling or moving heavy objects?	0=No, 1=Yes
if yes, fill ☞	_ _ How many months did you do this activity?	99=Unk
	_ _ How many times per month did you do this activity?	99=Unk
	_ _ _ How long did you do this activity on average each time? (# of minutes)	999=Unk

_	Do other strenuous sports such as basketball, football, skating, skiing, etc.?	0=No, 1=Yes
if yes, fill ☞	_ _ How many months did you do this activity?	99=Unk
	_ _ How many times per month did you do this activity?	99=Unk
	_ _ _ How long did you do this activity on average each time? (# of minutes)	999=Unk

Now, I'd like to ask you about more leisurely activities.

In the past 12 months for at least one hour total time in any month did you...

_	Do non-strenuous sports such as softball, shooting baskets, volleyball, ping pong, or leisurely jogging, swimming or biking, which we haven't included above?	0=No, 1=Yes
if yes, fill ☞	_ _ How many months did you do this activity?	99=Unk
	_ _ How many times per month did you do this activity?	99=Unk
	_ _ _ How long did you do this activity on average each time? (# of minutes)	999=Unk

TECH17

Physical Activity Questionnaire--Framingham Heart Study, Part 4

Tech-administered

Check here if whole page is blank. Reason why _____

In the past 12 months for at least one hour total time in any month did you..

<input type="checkbox"/>	Take walks or hikes or walk to work?	0=No, 1=Yes
if yes, fill	_ _ How many months did you do this activity?	99=Unk
	_ _ How many times per month did you do this activity?	99=Unk
	_ _ _ How long did you do this activity on average each time? (# of minutes)	999=Unk

<input type="checkbox"/>	Bowl or play golf?	0=No, 1=Yes
if yes, fill	_ _ How many months did you do this activity?	99=Unk
	_ _ How many times per month did you do this activity?	99=Unk
	_ _ _ How long did you do this activity on average each time? (# of minutes)	999=Unk

<input type="checkbox"/>	Do home exercise or calisthenics?	0=No, 1=Yes
if yes, fill	_ _ How many months did you do this activity?	99=Unk
	_ _ How many times per month did you do this activity?	99=Unk
	_ _ _ How long did you do this activity on average each time? (# of minutes)	999=Unk

<input type="checkbox"/>	Do home maintenance or gardening, including carpentry, painting, raking, mowing, etc.?	0=No, 1=Yes
if yes, fill	_ _ How many months did you do this activity?	99=Unk
	_ _ How many times per month did you do this activity?	99=Unk
	_ _ _ How long did you do this activity on average each time? (# of minutes)	999=Unk

<input type="checkbox"/>	Do weight training including free weights or machines such as Nautilus	0=No, 1=Yes
if yes, fill	_ _ How many months did you do this activity?	99=Unk
	_ _ How many times per month did you do this activity?	99=Unk
	_ _ _ How long did you do this activity on average each time? (# of minutes)	999=Unk

TECH18

Physical Activity Questionnaire--Framingham Heart Study, Part 5

Tech-administered

Check here if whole page is blank. Reason why _____

For each of the ages below, did you usually do moderate to vigorous exercise at least 3 times a week? This would include exercise that was long enough to work up a sweat and make your heart beat fast

Age	NO	YES	Does not recall	N/A <i>younger than stated age</i>
18 years old	0	1	9	8
35 years old	0	1	9	8
50 years old	0	1	9	8

Now I'm going to ask you some questions about your physical activity during the past year at WORK ONLY

<input type="checkbox"/>	Do you work? (if NO skip work related questions)	0=No, 1=Yes 9-Unk.
if yes, fill <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	How many hours per week do you work?	number of hrs. 999=Unk.

Please answer for the work you do most of the year if you are a seasonal worker

At work do you...	Never (0 hrs)	Seldom	Sometimes	Often	Always	Does not recall
Sit	0	1	2	3	4	9
Stand	0	1	2	3	4	9
Walk	0	1	2	3	4	9

My next question is about your leisure time

code as: 0=none or <1 hour, 1=1 hour, 2=2 hours, 3=3 hours, 4=4 hours 5=5 hours or more, 9=Unk..

In the past week, about how many hours per day did you sit and watch TV or videos?

In the past week, about how many hours per day did you use a computer or play computer games or play video games?

TECH19

Observed performance. Part 1 Technician Administered

Check here if whole page is blank. Reason why _____

_ _ _	Technician Number
-------	--------------------------

HAND GRIP TEST <i>Measured to the nearest kilogram</i>		
Right hand		
Trial 1	99=Unk.	_ _
Trial 2	99=Unk.	_ _
Trial 3	99=Unk.	_ _
Left hand		
Trial 1	99=Unk.	_ _
Trial 2	99=Unk.	_ _
Trial 3	99=Unk.	_ _

<input type="checkbox"/>	Check if this test not completed or not attempted.
_	If not attempted or completed, why not? 1=Physical limitation, 2=Refused, 3=Other _____write in, 9=Unk.

Comments: _____

TECH20

Observed performance. Part 2 Technician Administered

<input type="checkbox"/>	Check here if whole page is blank. Reason why _____
--------------------------	---

_ _ _	Technician Number
-------	--------------------------

Repeated Chair Stands	
Time to complete ten stands in seconds (99.99=Unk.)	_ _ * _ _
If less than ten stands, enter the number (99=Unk.)	_ _
IF OFFSITE visit, Chair height (in inches, 99*99=Unk.)	_ _ * _ _
<input type="checkbox"/> Check if this test not completed or not attempted.	
_	If not attempted or completed, why not? 1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.

Measured Walks - Quick Walk	
Walking aid used: (0=No aid, 1=Cane, 2=Walker, 3=Other, 9=Unk.)	_
Walk time (in seconds, 99.99=Unk.)	_ _ * _ _
Laser walk time (in seconds, 99.99=Unk.)	_ _ * _ _
<input type="checkbox"/> Check if this test not completed or not attempted.	
_	If not attempted or completed, why not? (1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.)

TECH21

Neurocognitive Questionnaire, Part 1 - CERAD Word List Memory Task: Learning Trials Technician Administered

Check here if whole page is blank. Reason why _____

□□□□

Technician Number

"In this next test you're going to be asked to remember some words. Just to let you know, most people usually cannot remember everything, which is fine. Whatever you do will be great."

Place flip book in front of participant

Now I am going to show you ten printed words. Read each word out loud as I show it to you. Later I will ask you to recall all ten words.

Present the words. After last word is read, say: Now, tell me as many as you can. **Start stopwatch.**

(Maximum time = 90 seconds. If participant reports being done before 90 seconds, move on to next trial.)

Trial 1		
Target Words	Check if incorrect word reading	Responses (verbatim)
Butter	<input type="checkbox"/>	1. _____
Arm	<input type="checkbox"/>	2. _____
Shore	<input type="checkbox"/>	3. _____
Letter	<input type="checkbox"/>	4. _____
Queen	<input type="checkbox"/>	5. _____
Cabin	<input type="checkbox"/>	6. _____
Pole	<input type="checkbox"/>	7. _____
Ticket	<input type="checkbox"/>	8. _____
Grass	<input type="checkbox"/>	9. _____
Engine	<input type="checkbox"/>	10. _____
		11. _____
		12. _____
		13. _____
		14. _____
		15. _____
		16. _____
		17. _____
		18. _____
		19. _____
		20. _____

Exposure time
1 word every 2 seconds

Maximum Recall time
90 seconds

Data Recording
Trial 1: check the appropriate box if the word was not read correctly.

All Trials: Write all words provided by the participant, in order, in the "Responses" column. .

TECH22

Neurocognitive Questionnaire, Part 2 - CERAD Word List Memory Task: Learning Trials Technician Administered

Check here if whole page is blank. Reason why _____

Technician Number same as CERAD Part 1.

I'm going to show you the same words again. As before, read them aloud as I show them to you.

Present the words, one word every 2 seconds. Then say "Now, tell me as many as you can."

Start Stopwatch

In the Responses column, record ALL words provided by the participant, in the exact order the participant says them. Do not correct the participant on Trials 2 and 3. (Maximum time = 90 seconds. If participant reports being done before 90 seconds, move on to next trial.)

Trial 2		Trial 3		
Target Words	Responses (verbatim)	Target Words	Responses (verbatim)	
Ticket	1. _____	Queen	1. _____	<p><u>Exposure time</u> 1 word every 2 seconds</p> <p><u>Maximum Recall time</u> 90 seconds</p>
Cabin	2. _____	Grass	2. _____	
Butter	3. _____	Arm	3. _____	
Shore	4. _____	Cabin	4. _____	
Engine	5. _____	Pole	5. _____	
Arm	6. _____	Shore	6. _____	
Queen	7. _____	Butter	7. _____	
Letter	8. _____	Engine	8. _____	
Pole	9. _____	Ticket	9. _____	
Grass	10. _____	Letter	10. _____	
	11. _____		11. _____	<p>Data Recording Write all words provided by the participant, in order, in the "Responses" column.</p>
	12. _____		12. _____	
	13. _____		13. _____	
	14. _____		14. _____	
	15. _____		15. _____	
	16. _____		16. _____	
	17. _____		17. _____	
	18. _____		18. _____	
	19. _____		19. _____	
	20. _____		20. _____	
Time of day that Learning Trial 3 is completed				_ _ * _ _

TECH23

Neurocognitive Questionnaire, Part 3 - Victoria Stroop Test (VST) Part 1: Dots Technician Administered

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
_ _ _	Technician's Number	

Place the "Dots" stimuli page in front of participant.

"Name the colors of the dots as quickly as you can. Begin here and go across the rows from left to right."

Direct the participant's eyes across the rows from left to right. Clarify, in your own words, if necessary. Once the participant understands the task say: "Ready, begin."

Start stopwatch immediately after telling participant to begin.

Correct any errors immediately (if not self-corrected) by pointing to the incorrect color patch while saying the correct response. Then say: "Now continue as fast as you can."

Coding: If an error is made, circle 1 if self-corrected or 2 if examiner-correct. If no error is made, check box next to color. Record the total time in the box at the bottom of the page.

DOTS							
Green <input type="checkbox"/>		Blue <input type="checkbox"/>		Yellow <input type="checkbox"/>		Red <input type="checkbox"/>	
1	2	1	2	1	2	1	2
Self-	Examiner-	Self-	Examiner-	Self-	Examiner-	Self-	Examiner-
Corrected	Corrected	Corrected	Corrected	Corrected	Corrected	Corrected	Corrected
Yellow <input type="checkbox"/>		Red <input type="checkbox"/>		Green <input type="checkbox"/>		Blue <input type="checkbox"/>	
1	2	1	2	1	2	1	2
Self-	Examiner-	Self-	Examiner-	Self-	Examiner-	Self-	Examiner-
Corrected	Corrected	Corrected	Corrected	Corrected	Corrected	Corrected	Corrected
Blue <input type="checkbox"/>		Green <input type="checkbox"/>		Yellow <input type="checkbox"/>		Red <input type="checkbox"/>	
1	2	1	2	1	2	1	2
Self-	Examiner-	Self-	Examiner-	Self-	Examiner-	Self-	Examiner-
Corrected	Corrected	Corrected	Corrected	Corrected	Corrected	Corrected	Corrected
Blue <input type="checkbox"/>		Yellow <input type="checkbox"/>		Red <input type="checkbox"/>		Green <input type="checkbox"/>	
1	2	1	2	1	2	1	2
Self-	Examiner-	Self-	Examiner-	Self-	Examiner-	Self-	Examiner-
Corrected	Corrected	Corrected	Corrected	Corrected	Corrected	Corrected	Corrected
Red <input type="checkbox"/>		Green <input type="checkbox"/>		Blue <input type="checkbox"/>		Yellow <input type="checkbox"/>	
1	2	1	2	1	2	1	2
Self-	Examiner-	Self-	Examiner-	Self-	Examiner-	Self-	Examiner-
Corrected	Corrected	Corrected	Corrected	Corrected	Corrected	Corrected	Corrected
Yellow <input type="checkbox"/>		Green <input type="checkbox"/>		Blue <input type="checkbox"/>		Red <input type="checkbox"/>	
1	2	1	2	1	2	1	2
Self-	Examiner-	Self-	Examiner-	Self-	Examiner-	Self-	Examiner-
Corrected	Corrected	Corrected	Corrected	Corrected	Corrected	Corrected	Corrected
Total Time				_ _ _ min		_ _ . _ _ sec	

TECH24

Neurocognitive Questionnaire, Part 4 - Victoria Stroop Test (VST) Part 2: Words Technician Administered

<input type="checkbox"/> Check here if whole page is blank.	Reason why _____
Technician's Number same as Stroop Part 1.	

Place the "Words" stimuli page in front of participant.

"This time name the colors of the words as quickly as you can. Begin here and go across the rows from left to right."

Direct the participant's eyes across the rows from left to right. Clarify, if necessary: "Name the colors in which the words are printed." Once the participant understands the task say: "Ready, begin."

Start stopwatch immediately after telling participant to begin.

Correct any errors immediately (if not self-corrected) by pointing to the incorrect color patch while saying the correct response. Then say: "Now continue as fast as you can."

Coding: If an error is made, circle 1 if self-corrected or 2 if examiner-correct. If no error is made, check box next to color. Record the total time in the box at the bottom of the page.

WORDS							
Green <input type="checkbox"/>		Blue <input type="checkbox"/>		Yellow <input type="checkbox"/>		Red <input type="checkbox"/>	
1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected
Yellow <input type="checkbox"/>		Red <input type="checkbox"/>		Green <input type="checkbox"/>		Blue <input type="checkbox"/>	
1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected
Blue <input type="checkbox"/>		Green <input type="checkbox"/>		Yellow <input type="checkbox"/>		Red <input type="checkbox"/>	
1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected
Blue <input type="checkbox"/>		Yellow <input type="checkbox"/>		Red <input type="checkbox"/>		Green <input type="checkbox"/>	
1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected
Red <input type="checkbox"/>		Green <input type="checkbox"/>		Blue <input type="checkbox"/>		Yellow <input type="checkbox"/>	
1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected
Yellow <input type="checkbox"/>		Green <input type="checkbox"/>		Blue <input type="checkbox"/>		Red <input type="checkbox"/>	
1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected
Total Time				_ _ _ min		_ _ . _ _ sec	

Neurocognitive Questionnaire, Part 5 - Victoria Stroop Test (VST) Part 3: Colors Technician Administered

<input type="checkbox"/> Check here if whole page is blank.	Reason why _____
Technician's Number same as Stroop Part 1.	

Place the "Colors" stimuli page in front of participant.

"Again, name the colors in which the words are printed as quickly as you can. Do NOT read the word, tell me the color in which the word is printed."

Direct the participant's eyes across the rows from left to right. Clarify, if necessary: "Name the colors in which the words are printed." Once the participant understands the task say: "Ready, begin."

Start stopwatch immediately after telling participant to begin.

Correct any errors immediately (if not self-corrected) by pointing to the incorrect color patch while saying the correct response. Then say: "Now continue as fast as you can."

Coding: If an error is made, circle 1 if self-corrected or 2 if examiner-correct. If no error is made, check box next to color. Record the total time in the box at the bottom of the page.

COLORS							
Green <input type="checkbox"/>		Blue <input type="checkbox"/>		Yellow <input type="checkbox"/>		Red <input type="checkbox"/>	
1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected
Yellow <input type="checkbox"/>		Red <input type="checkbox"/>		Green <input type="checkbox"/>		Blue <input type="checkbox"/>	
1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected
Blue <input type="checkbox"/>		Green <input type="checkbox"/>		Yellow <input type="checkbox"/>		Red <input type="checkbox"/>	
1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected
Blue <input type="checkbox"/>		Yellow <input type="checkbox"/>		Red <input type="checkbox"/>		Green <input type="checkbox"/>	
1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected
Red <input type="checkbox"/>		Green <input type="checkbox"/>		Blue <input type="checkbox"/>		Yellow <input type="checkbox"/>	
1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected
Yellow <input type="checkbox"/>		Green <input type="checkbox"/>		Blue <input type="checkbox"/>		Red <input type="checkbox"/>	
1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected	1 Self- Corrected	2 Examiner- Corrected
Total Time				_ _ _ min		_ _ . _ _ sec	

TECH26

Neurocognitive Questionnaire, Part 6 – Procedures during CERAD delay. Technician Administered

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
_ _ _	Technician's Number	

Procedures administered during CERAD Word List delay	
<i>Please, check ALL that apply</i>	
<input type="checkbox"/>	Anthropometry
<input type="checkbox"/>	Sociodemographic Questions
<input type="checkbox"/>	SF-12 Health Survey
<input type="checkbox"/>	CES-D Scale
<input type="checkbox"/>	Physical Activity Questionnaire
<input type="checkbox"/>	Neurocognitive: Victoria Stroop Test
<input type="checkbox"/>	Urine Specimen
<input type="checkbox"/>	Blood Draw
<input type="checkbox"/>	Glucose tolerance test
<input type="checkbox"/>	ECG
<input type="checkbox"/>	Observed performance (Fast walk, hand grip, chair stands)
<input type="checkbox"/>	Tonometry
<input type="checkbox"/>	Ankle-brachial blood pressure by Doppler. (Participants \geq 40 years)
<input type="checkbox"/>	Spirometry
<input type="checkbox"/>	Post albuterol Spirometry
<input type="checkbox"/>	Diffusion Capacity
<input type="checkbox"/>	Physician visit
<input type="checkbox"/>	Bone Density

TECH27

Neurocognitive Questionnaire, Part 7 - CERAD Word List Memory Task: Recall Technician Administered

Check here if whole page is blank. Reason why _____

____ Technician Number

A few minutes ago I asked you to learn a list of ten words which you read one at a time from pages in a book. Now I want you to try to recall those words. Go ahead and tell me as many of those ten words as you can remember.

Time of day that Recall test began

____*____

(Maximum time = 90 seconds. If participant reports being done before 90 seconds, move on to Recognition trial.)

Target Words	Responses (verbatim)
Queen	1. _____
Grass	2. _____
Arm	3. _____
Cabin	4. _____
Pole	5. _____
Shore	6. _____
Butter	7. _____
Engine	8. _____
Ticket	9. _____
Letter	10. _____
	11. _____
	12. _____
	13. _____
	14. _____
	15. _____
	16. _____
	17. _____
	18. _____
	19. _____
	20. _____

Exposure time

1 word every 2 seconds

Maximum Recall time

90 seconds

Data Recording

Write all words provided by the participant, in order, in the "Responses" column.

TECH28

Neurocognitive Questionnaire, Part 8 - CERAD Word List Memory Task: Recognition Technician Administered

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
Technician's Number same as CERAD Recall		

Place flip-book on desk in front of participant.

Now I am going to show you a set of words printed on separate pages. Some of the words are from the list you saw earlier and some are words I haven't shown you before. I want you to tell me which words are from the list you saw earlier.

Show the first word, ask: Is this one of the words you saw earlier?

<i>(Only YES or NO responses are acceptable.)</i>		
	NO	YES
Church	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Coffee	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Butter	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Dollar	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Arm	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Shore	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Five	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Letter	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Hotel	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Mountain	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Queen	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Cabin	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Slipper	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Pole	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Village	<input type="checkbox"/> 0	<input type="checkbox"/> 1
String	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Ticket	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Troops	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Grass	<input type="checkbox"/> 0	<input type="checkbox"/> 1
Engine	<input type="checkbox"/> 0	<input type="checkbox"/> 1

Code:
(check appropriate box)
0=No
1=Yes.”

TECH29

Neurocognitive Questionnaire, Part 9 - Factors affecting validity of data Technician Administered

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
_ _ _	Technician's Number	

CERAD	Victoria Stroop
<input type="checkbox"/> Were all portions of CERAD tape recorded? (0=No, 1 = Yes)	<input type="checkbox"/> Were all portions of Victoria Stroop tape recorded? (0=No, 1 = Yes)
<input type="checkbox"/> Check if Examiner believes something may have affected the validity of the data <i>(explain in comments section below)</i>	<input type="checkbox"/> Check if Examiner believes something may have affected the validity of the data <i>(explain in comments section below)</i>
<input type="checkbox"/> Check if test not completed	<input type="checkbox"/> Check if test not completed
Reason test not completed or factors that may have affected performance of completed test. Check ALL that apply	Reason test not completed or factors that may have affected performance of completed test. Check ALL that apply
<input type="checkbox"/> refused	<input type="checkbox"/> refused
<input type="checkbox"/> insufficient time	<input type="checkbox"/> insufficient time
<input type="checkbox"/> experimenter error	<input type="checkbox"/> experimenter error
<input type="checkbox"/> other <i>(explain in comments section below)</i>	<input type="checkbox"/> other <i>(explain in comments section below)</i>
<input type="checkbox"/>	<input type="checkbox"/> color blind <i>(for Stroop only)</i>
Comments: _____ _____ _____ _____ _____ _____	Comments: _____ _____ _____ _____ _____ _____

TECH30

Gen3 Exam 2 Framingham Study Vascular Function Participant Worksheet

(circle on)e

Keyer 1: _____

Keyer 2: _____

0 1 9

Have you had any caffeinated drinks in the last 6 hours?

(0=No, 1=Yes, 9=Unk.)

if yes
fill ☞

|_|_|

How many cups? (99=Unk.)

0 1 9

Have you eaten anything else including a fat free cereal bar this morning?

(0=No, 1=Yes, 9=Unknown)

0 1 9

Have you smoked cigarettes in the last 6 hours? (0=No, 1=Yes, 9=Unk.)if yes
fill ☞

|_|_|:|_|_|

If yes, how many hours and minutes since your last cigarette?
(99:99=Unk.)

Tonometry

|_|_|/|_|_|/|_|_|_|_| Date of Tonometry scan? (99/99/9999=Unk.)

|_|_|_|

Tonometry Sonographer ID

|_|_|_|-|_|_|_|

Tonometry CD number

0 1

Was Tonometry done?

0= No, test was not attempted or done

1= Yes, test was done, even if all 4 pulses could not be acquired and recorded.

If no fill ☞

Reason why: (Check all that apply) Subject refusal Subject discomfort Time constraint Equipment problem, specify _____ Other, specify _____

Not for Data Entry.

Distances:

_____ Carotid(mm) _____ Brachial(mm) _____ Radial(mm) _____ Femoral(mm)

Date of exam

____/____/____

**Framingham Heart Study
Gen 3 EXAM 2****Summary Sheet to Personal Physician**

Blood Pressure	First Reading	Second Reading
Systolic		
Diastolic		

ECG Diagnosis _____

The following tests are done on a routine basis: Blood Glucose, Blood Lipids, Pulmonary Function Test (results enclosed).

Summary of Findings _____**1. No history or physical exam findings to suggest cardiovascular disease.***(check box if applicable)*_____
Examining Physician*The Heart Study Clinic examination is not comprehensive and does not take the place of a routine physical examination.*

Referral Tracking

Check here if whole page is blank. Reason why _____

Was further medical evaluation recommended for this participant?
if yes fill below 0=No, 1=Yes, 9=Unk.

RESULT Reason for further evaluation: (Check ALL that apply).

Blood Pressure SBP or DBP
result ____/____ mmHg Phone call ≥ 200 or ≥ 110
Expedite ≥ 180 or ≥ 100
Elevated ≥ 140 or ≥ 90

Write in abnormality

ECG abnormality _____

Clinic Physician identified medical problem _____

Other _____

Method used to inform participant of need for further medical evaluation
(Check ALL that apply)

Face-to-face in clinic

Phone call

Result letter

Other

Method used to inform participant's personal physician of need for further medical evaluation (check ALL that apply)

Phone call

Result letter mailed

Result letter FAX'd (inform staff if Fax needed)

Other

Date referral made: ____/____/____

ID number of person completing the referral: _____

Notes documenting conversation with participant or participant's personal physician: _____

TECH31

Medical History—Hospitalizations, ER Visits, MD Visits

GEN 3 EXAM 2

DATE _____

DATE of last exam *«Lexam»*

DATE of last medical history update *«Lupdate»*

Health Care	
Since your last exam or medical history update	
_ _ _ _	1st Examiner ID _____ 1st Examiner Name
_	Hospitalizations (<i>not just E.R.</i>) (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unk.)
_	E.R. Visits (0=No; 1=Yes, 1 visit, 2=Yes, more than 1 visit, 9=Unk.)
_	Day Surgery (0=No, 1=Yes, 9=Unk.)
_	Major illness with visit to doctor (0=No, 1=Yes, 1 visit; 2=Yes, more than 1 visit; 9=Unk)
_	Check up by doctor or other health care provider? (0=No, 1=Yes, 9=Unk.)
_	Have you had a fever or infection in <u>past two weeks</u>? (0=No, 1=Yes, 9=Unk.)
_ _ _ _ _ _ _ _	Date of this FHS exam (<i>Today's date - See above</i>)
MM DD YYYY	

Medical Encounter	Month/Year (of last visit)	Name & Address of Hospital or Office	Doctor

MD01

Medical History—Medications

<input type="checkbox"/>	Do you take aspirin regularly? (0=No, 1=Yes, 9=Unk)	
If yes,	<input type="text"/>	Number of aspirins taken regularly (99=Unk.)
fill	<input type="text"/>	Frequency per (1=Day, 2=Week 3=Month, 4=Year, 9=Unk)
<input type="text"/>	<input type="text"/>	Usual dose (write in mgs, 999=Unk..)
		<u>Examples:</u> 081=baby,160=half dose, 250= like in Excedrin , 325=usual dose, 500=extra strength

Since your last exam		
(0=No, 1=Yes, 9=Unk)		
<input type="checkbox"/>	Have you been told by doctor you have high blood pressure or hypertension?	
<input type="checkbox"/>	Have you taken medication for high blood pressure or hypertension?	
<input type="checkbox"/>	Have you been told by doctor you have high blood cholesterol or high triglycerides?	
<input type="checkbox"/>	Have you taken medication for high blood cholesterol or high triglycerides?	
<input type="checkbox"/>	Have you been told by doctor you have high blood sugar or diabetes?	
<input type="checkbox"/>	Have you taken medication for high blood sugar or diabetes?	
<input type="checkbox"/>	Have you taken medication for cardiovascular disease? (for example angina/chest pain, heart failure, atrial fibrillation/heart rhythm abnormality, stroke, leg pain when walking, peripheral artery disease)	

MD02

Medical History – Prescription and Non-Prescription Medications

Copy the name of medicine, the strength including units, and the total number of doses per day/week/month/year. Include vitamins and minerals.

<input type="checkbox"/> Medication bag with medications brought to exam? (0=No 1=Yes)	**List medications taken regularly in past month/ongoing medications** <u>Code ASPIRIN ONLY on screen MD02.</u>
---	---

Medication Name (Print first 20 letters)	Strength (include mg, IU, etc)		Route 1= Oral, 2=topical, 3=injection, 4=inhaled, 5=drops,6=other	Number per (circle one)				PRN 0=no, 1=yes,9=Unk.	Check if OTC med	
				#	day	week	month/year			
EXAMPLE: S A M P L E	100	mg	1	1	D	W	M	Y	0	
					D	W	M	Y		<input type="checkbox"/>
					D	W	M	Y		<input type="checkbox"/>
					D	W	M	Y		<input type="checkbox"/>
					D	W	M	Y		<input type="checkbox"/>
					D	W	M	Y		<input type="checkbox"/>
					D	W	M	Y		<input type="checkbox"/>
					D	W	M	Y		<input type="checkbox"/>
					D	W	M	Y		<input type="checkbox"/>
					D	W	M	Y		<input type="checkbox"/>
					D	W	M	Y		<input type="checkbox"/>
					D	W	M	Y		<input type="checkbox"/>

Continue on the next page →

MD03

Medical History – Prescription and Non-Prescription Medications

Medication Name (Print first 20 letters)	Strength (include mg, IU, etc)		Route 1= Oral, 2=topical, 3=injection, 4=inhaled, 5=drops,6=other	Number per		PRN 0=no, 1=yes, 9-Unk	Check if OTC med.
				#	(circle one) day/week/month/year 1 / 2 / 3 / 4		
EXAMPLE: S A M P L E D R U G N A M E	100	mg	1	1	D W M Y	0	
					D W M Y		<input type="checkbox"/>
					D W M Y		<input type="checkbox"/>
					D W M Y		<input type="checkbox"/>
					D W M Y		<input type="checkbox"/>
					D W M Y		<input type="checkbox"/>
					D W M Y		<input type="checkbox"/>
					D W M Y		<input type="checkbox"/>
					D W M Y		<input type="checkbox"/>
					D W M Y		<input type="checkbox"/>
					D W M Y		<input type="checkbox"/>
					D W M Y		<input type="checkbox"/>
					D W M Y		<input type="checkbox"/>
					D W M Y		<input type="checkbox"/>

MD04

Medical History–Female Reproductive History. Part 1.

Check here if Male Participant (and skip to Smoking Questions page 52/MD08)

_	Since your last exam have you taken or used birth control pills, shots, or hormone implants for birth control or medical indications (not post menopausal hormone replacement)? (0=no, 1=yes, now, 2=yes, not now, 9=Unk.)		
_	Have you ever tried to become pregnant for ≥ 1 year without becoming pregnant? (0=No, 1=Yes, 9=Unk.)		
_	Have you been pregnant since last exam? (0=no, 1=yes, 9=Unk.)		
If yes,	_ _	Number of pregnancies?	fill in number
fill	_ _	Number of live births?	
_	During any of these pregnancies, were you told you had high blood pressure or hypertension?		0=No
_	During any of these pregnancies, were you told you had eclampsia, pre-eclampsia (toxemia)		1=Yes
_	During any of these pregnancies, were you told you had high blood sugar or diabetes?		9=Unk

Now, I would like to ask you about how much each of your children weighed at birth and whether you breastfed.

Check if no live birth and skip this section.

Questions about your babies (All Live Births)					
Baby #	Full term?	Birth weight		Breast feeding or expressed breast milk	
	0=<37 weeks 1= \geq 37 weeks 9=Unk.	pounds 99=Unk.	ounces 99=Unk.	Did you breast feed? 0=No 1=Yes 9=Unk.	If yes, how long 1=<6 weeks, 2=6 to 11 weeks, 3=3 to 6 months, 4=>6 months, 9=Unk.
#1	_	_ _	_ _	_	_
#2	_	_ _	_ _	_	_
#3	_	_ _	_ _	_	_
#4	_	_ _	_ _	_	_
#5	_	_ _	_ _	_	_
#6	_	_ _	_ _	_	_
#7	_	_ _	_ _	_	_

MD05

Medical History–Female Reproductive History. Part 2

What is the best way to describe your periods? Check the BEST answer – *only one*.

- Not stopped**
- Periods stopped due to pregnancy, breast feeding, or hormonal contraceptive** (for example: depo-provera, progestin releasing IUD, extended release birth control pill)
- Periods stopped due to low body weight, heavy exercise, or due to medication or health condition such as thyroid disease, pituitary tumor, hormone imbalance, stress,**
 Write in cause _____
- Periods stopped for less than 1 year (perimenopausal)**
 |__|__| Number of months since last period 99=Unk.
- Periods stopped for 1 year or more**
- Periods stopped, but now have periods induced by hormones.**
 |__|__| Number months stopped before hormones started. 99=Unk.

- |__|__|*|__|__|*|__|__|__|__| **When was the first day of your last menstrual period?** 99/99/9999=Unk.
 88/88/8888= periods stopped for more than 1 year or using postmenopausal hormones
- |__|__|__| **Normally how many days are there between your periods (start to start)?** 999=Unk.
 888= periods stopped for more than 1 year or using postmenopausal hormones
- |__|__| **How many periods have you had in past 12 months?** 99=Unk.
 88= periods stopped for more than 1 year or using postmenopausal hormones
- |__|__| **Age when periods stopped** (00=not stopped, 99=Unk.)
 If periods now induced by hormones, code age when periods naturally stopped.
 If periods stopped due to pregnancy, breast feeding, or hormonal contraception code as “0=not stopped”
- |__| **Was your menopause natural or the result of surgery, chemotherapy, or radiation?**
 (0=still menstruating, 1=natural, 2=surgical, 3=chemo/radiation, 4=other, 9=Unk.)
 If periods stopped due to pregnancy, breast feeding, or hormonal contraception code as “0=still menstruating”
- |__| **Have you since your last exam taken hormone replacement therapy (estrogen/progesterone) or a selective estrogen receptor modulator (such as evista or raloxifene)?**
 (0=no, 1=yes, now, 2=yes, not now, 9=Unk.)

MD06

Medical History–Female Reproductive History. Part 3

Surgery History

Since your last exam have you had a hysterectomy (uterus/womb removed)? (0=no, 1=yes, 9=Unk.)

If yes,
fill 

Age at hysterectomy? 99=Unk.

* Date of surgery (mo/yr) 99/9999=Unk.

Since last exam have you had an operation to remove one or both of your ovaries?
(0=no, 1=yes, 9=Unk.)

If yes,
fill 

Age when ovaries removed? *If more than one surgery, use age at last surgery* 99=Unk.

Number of ovaries removed? (check one)

1=one ovary

2=two ovaries

3= unknown. number of ovaries

4= part of an ovary

Comments _____

MD07

Medical History--Smoking

Cigarettes																			
<input type="checkbox"/>	Since your last exam have you smoked cigarettes regularly? (0=no, 1=yes, 9=Unk.)																		
If yes, fill	<table style="width: 100%;"> <tr> <td style="width: 10%; text-align: center;"><input type="checkbox"/></td> <td>Have you smoked cigarettes regularly in the last year? (<i>No means less than 1 cigarette a day for 1 year.</i>) (0=no, 1=yes, 9=Unk.)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>Do you now smoke cigarettes (as of 1 month ago)? (0=no, 1=yes, 9=Unk.)</td> </tr> <tr> <td style="text-align: center;"><input style="width: 40px;" type="text"/></td> <td>How many cigarettes do you smoke per day now? (99=Unk.)</td> </tr> </table> <p><i>Questions below refer to "whole lifetime"</i></p> <table style="width: 100%;"> <tr> <td style="width: 10%; text-align: center;"><input style="width: 40px;" type="text"/></td> <td>On the average of the entire time you smoked, how many cigarettes did you smoke per day? (99=Unk.)</td> </tr> <tr> <td style="text-align: center;"><input style="width: 40px;" type="text"/></td> <td>How old were you when you first started regular cigarette smoking? (99=Unk.)</td> </tr> <tr> <td style="text-align: center;"><input style="width: 40px;" type="text"/></td> <td>If you have stopped smoking cigarettes completely, how old were you when you stopped? (Age stopped, 00=not stopped, 99=Unk.)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>When you were smoking, did you ever stop smoking for >6 months? (0=no, 1=yes, 9=Unk.)</td> </tr> <tr> <td style="vertical-align: top;">If yes, fill </td> <td> <table style="width: 100%;"> <tr> <td style="width: 10%; text-align: center;"><input style="width: 40px;" type="text"/></td> <td>For how many years in total did you stop smoking cigarettes (1=6 months – 1 year, 99=Unk.)</td> </tr> </table> </td> </tr> </table>	<input type="checkbox"/>	Have you smoked cigarettes regularly in the last year? (<i>No means less than 1 cigarette a day for 1 year.</i>) (0=no, 1=yes, 9=Unk.)	<input type="checkbox"/>	Do you now smoke cigarettes (as of 1 month ago)? (0=no, 1=yes, 9=Unk.)	<input style="width: 40px;" type="text"/>	How many cigarettes do you smoke per day now? (99=Unk.)	<input style="width: 40px;" type="text"/>	On the average of the entire time you smoked, how many cigarettes did you smoke per day? (99=Unk.)	<input style="width: 40px;" type="text"/>	How old were you when you first started regular cigarette smoking? (99=Unk.)	<input style="width: 40px;" type="text"/>	If you have stopped smoking cigarettes completely, how old were you when you stopped? (Age stopped, 00=not stopped, 99=Unk.)	<input type="checkbox"/>	When you were smoking, did you ever stop smoking for >6 months? (0=no, 1=yes, 9=Unk.)	If yes, fill	<table style="width: 100%;"> <tr> <td style="width: 10%; text-align: center;"><input style="width: 40px;" type="text"/></td> <td>For how many years in total did you stop smoking cigarettes (1=6 months – 1 year, 99=Unk.)</td> </tr> </table>	<input style="width: 40px;" type="text"/>	For how many years in total did you stop smoking cigarettes (1=6 months – 1 year, 99=Unk.)
<input type="checkbox"/>	Have you smoked cigarettes regularly in the last year? (<i>No means less than 1 cigarette a day for 1 year.</i>) (0=no, 1=yes, 9=Unk.)																		
<input type="checkbox"/>	Do you now smoke cigarettes (as of 1 month ago)? (0=no, 1=yes, 9=Unk.)																		
<input style="width: 40px;" type="text"/>	How many cigarettes do you smoke per day now? (99=Unk.)																		
<input style="width: 40px;" type="text"/>	On the average of the entire time you smoked, how many cigarettes did you smoke per day? (99=Unk.)																		
<input style="width: 40px;" type="text"/>	How old were you when you first started regular cigarette smoking? (99=Unk.)																		
<input style="width: 40px;" type="text"/>	If you have stopped smoking cigarettes completely, how old were you when you stopped? (Age stopped, 00=not stopped, 99=Unk.)																		
<input type="checkbox"/>	When you were smoking, did you ever stop smoking for >6 months? (0=no, 1=yes, 9=Unk.)																		
If yes, fill	<table style="width: 100%;"> <tr> <td style="width: 10%; text-align: center;"><input style="width: 40px;" type="text"/></td> <td>For how many years in total did you stop smoking cigarettes (1=6 months – 1 year, 99=Unk.)</td> </tr> </table>	<input style="width: 40px;" type="text"/>	For how many years in total did you stop smoking cigarettes (1=6 months – 1 year, 99=Unk.)																
<input style="width: 40px;" type="text"/>	For how many years in total did you stop smoking cigarettes (1=6 months – 1 year, 99=Unk.)																		

Pipes or Cigars				
<input type="checkbox"/>	Since your last exam, have you regularly smoked a pipe or cigar?	0=No 1=Yes 9=Unk.		
If yes, fill	<table style="width: 100%;"> <tr> <td style="width: 10%; text-align: center;"><input type="checkbox"/></td> <td>Do you smoke a pipe or cigar now</td> </tr> </table>	<input type="checkbox"/>	Do you smoke a pipe or cigar now	
<input type="checkbox"/>	Do you smoke a pipe or cigar now			

Comments: _____

MD08

Medical History –Alcohol Consumption.

Now I will ask you questions regarding your alcohol use.

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

_ _ _	At what age did you stop drinking alcohol? (0= not stopped, 888=Never drinker 999=Unk.)
-------	--

<input type="checkbox"/>	Over the past year, on average on how many days per week did you drink an alcoholic beverage of any type? (0=no drinks, 1=1 or less, 9=Unk.)
_ _	Over the past year, on a typical day when you drink, how many drinks do you have? (0=no drinks, 1=1 or less, 99=Unk.)
_ _	What was the maximum number of drinks you had in 24 hr. period during the past month? (0=no drinks, 1=1 or less, 99=Unk.)
<input type="checkbox"/>	Since last exam has there been a time when you drank 5 or more alcoholic drinks of any kind almost daily? (0=no, 1=yes, 9=Unk.)

<input type="checkbox"/>	Check if over past year participant drinks less than one alcoholic drink of any type per month.
--------------------------	--

Comments: _____

MD09

Medical History—Respiratory Symptoms. Part 1

Cough (0=No, 1=Yes, 9=Unk.)	
<input type="checkbox"/>	Do you usually have a cough? <i>(Exclude clearing of the throat)</i>
<input type="checkbox"/>	Do you usually have a cough at all on getting up or first thing in the morning?
If YES to either question above answer the following:	
<input type="checkbox"/>	Do you cough like this on most days for three consecutive months or more during the past year?
<input type="checkbox"/>	How many years have you had this cough? (# of years.)
	1=1 year or less 99=Unk

Phlegm (0=No, 1=Yes, 9=Unk.)	
<input type="checkbox"/>	Do you usually bring up phlegm from your chest?
<input type="checkbox"/>	Do you usually bring up phlegm at all on getting up or first thing in the morning?
If YES to either question above answer the following:	
<input type="checkbox"/>	Do you bring up phlegm from your chest on most days for three consecutive months or more during the year?
<input type="checkbox"/>	How many years have you had trouble with phlegm? (# of years)
	1=1 year or less 99=Unk

MD10

Medical History—Respiratory Symptoms. Part 2



Wheeze (0=No, 1=Yes, 9=Unk.)	
In the past 12 months...	
<input type="checkbox"/>	Have you had wheezing or whistling in your chest at any time?
if yes, fill all	How often have you had this wheezing or whistling? 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=Unk.
<input type="checkbox"/>	Have you had this wheezing or whistling in the chest when you had a cold?
<input type="checkbox"/>	Have you had this wheezing or whistling in the chest apart from colds?
<input type="checkbox"/>	Have you had an attack of wheezing or whistling in the chest that had made you feel short of breath?

Sleep Related Symptoms (days/nights)	
In the past 12 months...	
<input type="checkbox"/>	On average how many nights a week did you snore?
<input type="checkbox"/>	On average how many nights a week do you snort, gasp, or stop breathing while you are asleep?
<input type="checkbox"/>	On average how many days a week have you had excessive (too much) daytime sleepiness?
	0=NEVER 1=RARELY(1-2 nights/week) 2=OCCASIONALLY(3-4 nights/week) 3=FREQUENTLY(5/more nights/week) 8=I DON'T KNOW. 9=UNK.

Nocturnal chest symptoms (0=No, 1=Yes, 9=Unk.)	
In the past 12 months...	
<input type="checkbox"/>	Have you been awakened by shortness of breath?
<input type="checkbox"/>	Have you been awakened by a wheezing/whistling in your chest?
<input type="checkbox"/>	Have you been awakened by coughing?
if yes, fill all	How often have you been awakened by coughing? 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=Unk.

MD11

Medical History—Respiratory Symptoms. Part 3

Shortness of breath (0=No, 1=Yes, 9=Unk.)	
Since your last exam...	
<input type="checkbox"/>	Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?
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 have to stop for breath when walking at your own pace on level ground?
	<input type="checkbox"/> Do you have to stop for breath after walking 100 yards (or after a few minutes) on level ground?
<input type="checkbox"/>	Do you/have you needed to sleep on two or more pillows to help you breathe (Orthopnea)?
<input type="checkbox"/>	Have you since last exam had swelling in both your ankles (ankle edema)?
<input type="checkbox"/>	Have you been told by your doctor you had heart failure or congestive heart failure?
if yes, fill 	Name of doctor _____
	Date of visit __ _* __ _* __ _ 99/99/9999=Unk.
<input type="checkbox"/>	Have you been hospitalized for heart failure? (Provide details on MD01-Health Care page 47)

CHF First Examiner Opinion	
<input type="checkbox"/>	First examiner believes CHF 0=No, 1=Yes 2=Maybe, 9=Unk.

Comments _____

MD12

Physical Exam—Blood Pressure

Physician Blood Pressure	
First reading	
Systolic	BP cuff size
 to nearest 2 mm Hg	 0=pedi, 1=reg.adult, 2=large adult, 3= thigh, 9=Unk.
Diastolic	Protocol modification
 to nearest 2 mm Hg	 0=No, 1=Yes, 9=Unk.

Comments for Protocol modification _____

MD13

Medical History—Chest pain







<input type="checkbox"/>	Since your last exam have you experienced any chest discomfort? <i>(please provide narrative comments in addition to completing the appropriate boxes)</i>	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill	<input type="checkbox"/> Chest discomfort with exertion or excitement	
and below	<input type="checkbox"/> Chest discomfort when quiet or resting	
Chest Discomfort Characteristics		
<input type="text"/>	Date of onset <i>(mo/yr)</i>	99/9999=Unk.
<input type="text"/>	Usual duration <i>(minutes)</i>	1=1 min or less, 900=15 hrs or more, 999=Unk.
<input type="text"/>	Longest duration <i>(minutes)</i>	1=1 min or less, 900=15 hrs or more, 999=Unk.
<input type="text"/>	Location	0=No, 1=Central sternum and upper chest, 2=L Up Quadrant, 3=L Lower ribcage, 4=R Chest, 5=Other, 6=Combination, 9=Unk.
<input type="text"/>	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=Unk.
<input type="text"/>	Number of episodes of chest pain in past month	999=Unk.
<input type="text"/>	Number of episodes of chest pain in past year.	999=Unk.
<input type="text"/>	Type	1=Pressure, heavy, vise, 2=Sharp, 3=Dull, 4=Other, 9=Unk.
<input type="text"/>	Relief by Nitroglycerin in <15 minutes	0=No,
<input type="text"/>	Relief by Rest in <15 minutes	1=Yes,
<input type="text"/>	Relief Spontaneously in <15 minutes	8= <i>Not tried</i>
<input type="text"/>	Relief by Other cause in <15 minutes	9=Unk.


<input type="checkbox"/>	Since your last exam have you been told by a doctor you had a heart attack or myocardial infarction?	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill	Name of doctor _____	
	Date of visit <input type="text"/> * <input type="text"/> * <input type="text"/>	99/99/9999=Unk.

CHD First Examiner Opinions		
<input type="checkbox"/>	Angina pectoris	0=No,
if yes, fill	<input type="checkbox"/> Angina pectoris since revascularization procedure	1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	Coronary insufficiency	
<input type="checkbox"/>	Myocardial infarct	

Comments _____

Medical History—Atrial Fibrillation/Syncope

Since your last exam or medical history update...		
<input type="checkbox"/>	Have you been told you have/had atrial fibrillation?	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill 	<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.
<input type="checkbox"/>	ER/hospitalized or saw M.D.	0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unk.
if yes, fill 	_____ Name of the Hospital (write Unk. if unknown)	
	_____ Name of M.D. (write Unk. if unknown)	
<input type="checkbox"/>	Have you fainted or lost consciousness? <i>(If event immediately preceded by head injury or accident code 0=No)</i>	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill all 	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Number of episodes in the past two years	999=Unk.
	<input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of first episode (mo/yr)	99/9999=Unk.
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Usual duration of loss of consciousness (minutes)	999=Unk., 1=1 min or less
<input type="checkbox"/>	Did you have any injury caused by the event?	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	ER/hospitalized or saw M.D.	0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unk.
if yes, fill 	_____ Name of the Hospital (write Unk. if unknown)	
	_____ Name of M.D. (write Unk. if unknown)	
<input type="checkbox"/>	Have you had a head injury with loss of consciousness?	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill 	<input type="text"/> * <input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of serious head injury with loss of consciousness	99/99/9999=Unk.
<input type="checkbox"/>	Have you had a seizure?	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill 	<input type="text"/> * <input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of most recent seizure	99/99/9999=Unk.
<input type="checkbox"/>	Are you being treated for a seizure disorder?	0=No, 1=Yes, 2=Maybe, 9=Unk.

Syncope First Examiner Opinion		
<input type="checkbox"/>	Syncope (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unk.) <i>needs second opinion</i>	
if yes, fill 	<input type="checkbox"/> Cardiac syncope	0=No,
	<input type="checkbox"/> Vasovagal syncope	1=Yes,
	<input type="checkbox"/> Other-Specify: _____	2=Maybe,
		9=Unk.

Comments: _____

MD15

Medical History—Cerebrovascular Disease, Part 1

Since your last exam or medical history update have you had..		
<input type="checkbox"/>	Sudden muscular weakness	0=No,
<input type="checkbox"/>	Sudden speech difficulty	1=Yes,
<input type="checkbox"/>	Sudden visual defect	2=Maybe,
<input type="checkbox"/>	Sudden double vision	9=Unk.
<input type="checkbox"/>	Sudden loss of vision in one eye	
<input type="checkbox"/>	Sudden numbness, tingling	
if yes, fill ☞	<input type="checkbox"/> Numbness and tingling is positional	
<input type="checkbox"/>	Head CT scan <i>OTHER THAN FOR THE FHS</i>	0=No,1=Yes, 2= Maybe,9=Unk.
if yes, fill ☞	<input type="text"/> * <input type="text"/> * <input type="text"/> _____ Date	99/99/9999=Unk.
	_____ Place	
<input type="checkbox"/>	Head MRI scan <i>OTHER THAN FOR THE FHS</i>	0=No,1=Yes, 2= Maybe,9=Unk.
if yes, fill ☞	<input type="text"/> * <input type="text"/> * <input type="text"/> _____ Date	99/99/9999=Unk.
	_____ Place	
<input type="checkbox"/>	Seen by neurologist (write in who and when below.) _____	
<input type="checkbox"/>	Have you been told by a doctor you had a stroke or TIA (transient ischemic attack, mini-stroke)?	0=No, 1=Yes,
<input type="checkbox"/>	Have you been told by a doctor you have Parkinson Disease?	2=Maybe,
<input type="checkbox"/>	Have you been told by a doctor you have memory problems, dementia or Alzheimer's disease?	9=Unk.
<input type="checkbox"/>	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?	

Cerebrovascular Disease First Examiner Opinion

<input type="checkbox"/>	TIA or stroke took place	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes or maybe fill ☞	<input type="text"/> * <input type="text"/> Date (mo/yr, 99/9999=Unk.)	
	Observed by _____	
	<input type="text"/> * <input type="text"/> * <input type="text"/> Duration (use format days/hours/mins, 99/99/99=Unk.)	
<input type="checkbox"/>	Hospitalized or saw M.D. (0=No, 1=Hosp.,2=Saw M.D, 9=Unk)	

Comments _____

Medical History--Venous and Peripheral Arterial Disease**Venous Disease**

Since your last exam or medical history update have you had...

<input type="checkbox"/>	Deep Vein Thrombosis - DVT (blood clots in legs or arms)	0=No,1=Yes,
<input type="checkbox"/>	Pulmonary Embolus – PE (blood clot in lungs)	2=Maybe, 9=Unk.

Peripheral Arterial Disease

Since your last exam have you had...

<input type="checkbox"/>	Do you get discomfort in either leg on walking? (0=No, 1=Yes, 9=Unk.)
--------------------------	--

if yes,
fill

<input type="checkbox"/>	Does this discomfort ever begin when you are standing still or sitting? (0=no, 1=yes, 9=Unk.)
--------------------------	--

<input type="checkbox"/>	When walking at an ordinary pace on level ground, how many city blocks until symptoms develop (1=1 block or less, 99=Unk.) <i>where 10 blocks=1 mile, code as no if more than 98 blocks required to develop symptoms</i>
--------------------------	---

Left	Right	Claudication symptoms	0=No, 1=Yes, 9=Unk.
------	-------	-----------------------	---------------------

<input type="checkbox"/>	<input type="checkbox"/>	Discomfort in calf while walking	
--------------------------	--------------------------	---	--

<input type="checkbox"/>	<input type="checkbox"/>	Discomfort in lower extremity (not calf) while walking Write in site of discomfort _____	
--------------------------	--------------------------	--	--

<input type="checkbox"/>	Occurs with first steps (code worse leg)
--------------------------	---

<input type="checkbox"/>	Do you get the discomfort when you walk up hill or hurry?
--------------------------	--

<input type="checkbox"/>	Does the discomfort ever disappear while you are still walking?
--------------------------	--

<input type="checkbox"/>	What do you do if you get discomfort when you are walking? (1=stop, 2=slow down, 3=continue at same pace, 9=Unk.)
--------------------------	--

<input type="checkbox"/>	Time for discomfort to be relieved by stopping (minutes) (000=No relief with stopping, 999=Unk.)
--------------------------	--

<input type="checkbox"/>	Number of days/month of lower limb discomfort (1=1 day/month or less, 99=Unk.)
--------------------------	---

<input type="checkbox"/>	Since your last exam have you been told by a doctor you have intermittent claudication or peripheral artery disease? (0=No, 1=Yes, 9=Unk.)
--------------------------	---

if yes,
fill

<input type="checkbox"/>	Name of doctor _____
--------------------------	-----------------------------

<input type="checkbox"/>	Date of visit __ * __ * __ __ __ __ 99/99/9999=Unk.
--------------------------	--

<input type="checkbox"/>	Since your last exam have you been told by a doctor you have spinal stenosis? (0=No, 1=Yes, 9=Unk.)
--------------------------	--











Intermittent Claudication First Examiner Opinion

<input type="checkbox"/>	Intermittent Claudication	0=No, 1=Yes, 2=Maybe, 9=Unk.
--------------------------	----------------------------------	------------------------------

Comments _____

Medical History-- CVD Procedures

Since your last exam or medical history update did you have any of the following cardiovascular procedures?

0=No, 1=Yes 2=Maybe, 9=Unk.		Cardiovascular Procedures <i>(if procedure was repeated code only first and provide narrative)</i>	
<input type="checkbox"/>		Heart Valvular Surgery	
	if yes fill 	<input type="text"/>	Year done (9999=Unk)
<input type="checkbox"/>		Exercise Tolerance Test	
	if yes fill 	<input type="text"/>	Year done (9999=Unk)
<input type="checkbox"/>		Coronary arteriogram	
	if yes fill 	<input type="text"/>	Year done (9999=Unk)
<input type="checkbox"/>		Coronary artery angioplasty or stent	
	if yes fill 	<input type="text"/>	Year done (9999=Unk)
<input type="checkbox"/>		Coronary bypass surgery	
	if yes fill 	<input type="text"/>	Year done (9999=Unk)
<input type="checkbox"/>		Permanent pacemaker insertion	
	if yes fill 	<input type="text"/>	Year done (9999=Unk)
<input type="checkbox"/>		Carotid artery surgery or stent	
	if yes fill 	<input type="text"/>	Year done (9999=Unk)
<input type="checkbox"/>		Thoracic aorta surgery	
	if yes fill 	<input type="text"/>	Year done (9999=Unk)
<input type="checkbox"/>		Abdominal aorta surgery	
	if yes fill 	<input type="text"/>	Year done (9999=Unk)
<input type="checkbox"/>		Femoral or lower extremity surgery	
	if yes fill 	<input type="text"/>	Year done (9999=Unk)
<input type="checkbox"/>		Lower extremity amputation	
	if yes fill 	<input type="text"/>	Year done (9999=Unk)
<input type="checkbox"/>		Other Cardiovascular Procedure (write in below)	
	if yes fill 	<input type="text"/>	Year done (9999=Unk) Description _____

Write in other procedures, year done, location if more than one.

Comments: _____

Physical Exam—Blood Pressure

Physician Blood Pressure Second reading	
Systolic	BP cuff size
_ _ _ to nearest 2 mm Hg	_ 0=pedi, 1=reg.adult, 2=large adult, 3= thigh, 9=Unk.
Diastolic	Protocol modification
_ _ _ to nearest 2 mm Hg	_ 0=No, 1=Yes, 9=Unk.

Comments for Protocol modification _____

MD19

Cancer Site or Type

Since your last exam or medical history update have you had a cancer or a tumor?
(0=No and skip to next page MD21; If 1=Yes, 2=Maybe, 9=Unk. please continue)

Check ALL that apply	Site of Cancer or Tumor	Year First Diagnosed	Cancer	Maybe cancer	Benign	Name Diagnosing M.D.	City/State of M.D.
			Check ONE				
			1	2	3		
<input type="checkbox"/>	Esophagus		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Stomach		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Colon		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Rectum		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Pancreas		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Larynx		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Trachea/Bronchus/ Lung		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Leukemia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Skin		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Breast		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Cervix/Uterus		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Ovary		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Prostate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Bladder		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Kidney		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Brain		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Lymphoma		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	Other/Unk. _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

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

MD20

Physical Exam—Respiratory, Heart and Abdomen

Respiratory

<input type="checkbox"/>	Wheezing on auscultation	0=No,
<input type="checkbox"/>	Rales	1=Yes,
<input type="checkbox"/>	Abnormal breath sounds	2=Maybe,
		9=Unk.

Heart

<input type="checkbox"/>	S3 Gallop	0=No,
<input type="checkbox"/>	S4 Gallop	1=Yes,
<input type="checkbox"/>	Systolic Click	2=Maybe,
<input type="checkbox"/>	Neck vein distention at 90 degrees (sitting upright)	9=Unk.

<input type="checkbox"/>	Systolic murmur(s)			0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/> if yes, fill below	Grade	Type	Radiation	
Murmur Location	0=No sound 1 to 6 for grade of sound heard 9=Unk.	0=None 1=Ejection 2=Regurgitant 3=Other 9=Unk.	0=None 1=Axilla 2=Neck 3=Back 4=Rt. chest 9=Unk.	
Apex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Left Sternum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Base	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	Diastolic murmur(s)			0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/> if yes, fill	<input type="checkbox"/>	Valve of origin for diastolic murmur(s) (1=Mitral, 2=Aortic, 3=Both, 4=Other, 8=N/A, 9=Unk)		

Abdominal Abnormalities

<input type="checkbox"/>	Liver enlarged	0=No,
<input type="checkbox"/>	Abdominal aneurysm	1=Yes,
<input type="checkbox"/>	Abdominal bruit	2=Maybe,
		9=Unk.

Comments _____

MD21

Physical Exam--Peripheral Vessels--Part I

Left	Right	Lower Extremity Abnormalities
<input type="checkbox"/>	<input type="checkbox"/>	Stem varicose veins (Do not code reticular or spider varicosities) (0=No abnormality 1=Yes 9=Unk.)
<input type="checkbox"/>	<input type="checkbox"/>	Ankle edema (0=No, 1=Yes, 2=Maybe, 8=absent due to amputation 9=Unk.)
<input type="checkbox"/>	<input type="checkbox"/>	Amputation level (0=No, 1=Toes only, 2=Foot, 3=below Knee, 4=above Knee, 5= Other, write in _____, 9=Unk.)

Artery	Pulse (0=Normal, 1=Abnormal, 9=Unk.)		Bruit (0=Normal, 1=Abnormal, 9=Unk.)	
	Left	Right	Left	Right
Femoral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Popliteal			<input type="checkbox"/>	<input type="checkbox"/>
Post Tibial	<input type="checkbox"/>	<input type="checkbox"/>		
Dorsalis Pedis	<input type="checkbox"/>	<input type="checkbox"/>		

Comments _____

MD22

Physical Exam--Neurological Exam

Neurological Exam			
Left	Right		
<input type="checkbox"/>	<input type="checkbox"/>	Carotid Bruit	
	<input type="checkbox"/>	Speech disturbance	0=No,
	<input type="checkbox"/>	Disturbance in gait	1=Yes,
	<input type="checkbox"/>	Other neurological abnormalities on exam	2=Maybe,
	<input type="checkbox"/>	Specify _____	9=Unk.

Comments _____

MD23

Electrocardiograph--Part I

OFFSITE ONLY		
_ _ _	MD Id# _____	MD Name

Rates and Intervals		
_ _ _	Ventricular rate per minute	(999=Unk.)
_ _ _	P-R Interval (milliseconds)	(999=Fully Paced, Atrial Fib, or Unk.)
_ _ _	QRS interval (milliseconds)	(999=Fully Paced, Unk.)
_ _ _	Q-T interval (milliseconds)	(999=Fully Paced, Unk.)
_ _ _ _	QRS angle (put plus or minus as needed)	(e.g. -045 for minus 45 degrees, +090 for plus 90, 9999=Fully paced or Unk.)

Rhythm--predominant	
_	0 or 1 = Normal sinus , (including s.tach, s.brady, s arrhy, 1 degree AV block) 3 = 2nd degree AV block, Mobitz I (Wenckebach) 4 = 2nd degree AV block, Mobitz II 5 = 3rd degree AV block / AV dissociation 6 = Atrial fibrillation / atrial flutter 7 = Nodal 8 = Paced 9 = Other or combination of above (list)

Ventricular conduction abnormalities		
_	IV Block	(0=No, 1=Yes, 9=Fully paced or Unk.)
if yes, fill	_ Pattern	(1=Left, 2=Right, 3=Indeterminate, 9=Unk.)
	_ Complete (QRS interval=.12 sec or greater)	(0=No, 1=Yes, 9=Unk.)
	_ Incomplete (QRS interval = .10 or .11 sec)	(0=No, 1=Yes, 9=Unk.)
_	Hemiblock	(0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unk.)
_	WPW Syndrome	(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.)

Arrhythmias		
_	Atrial premature beats	(0=No, 1=Atr, 2=Atr Aber, 9=Unk.)
_	Ventricular premature beats	(0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)
_ _	Number of ventricular premature beats in 10 seconds	(see 10 second rhythm strip)

MD24

Electrocardiograph-Part II

Myocardial Infarction Location		
<input type="checkbox"/>	Anterior	0=No,
<input type="checkbox"/>	Inferior	1=Yes,
<input type="checkbox"/>	True Posterior	2=Maybe,
		9=Fully paced or Unk.

Left Ventricular Hypertrophy Criteria		
<input type="checkbox"/>	R > 20mm in any limb lead	0=No,
<input type="checkbox"/>	R > 11mm in AVL	1=Yes,
<input type="checkbox"/>	R in lead I plus S in lead III \geq 25mm	9=Fully paced, Complete LBBB or Unk
Measured Voltage		
* <input type="checkbox"/>	R AVL in mm (at 1 mv = 10 mm standard) Be sure to code these voltages	
* <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 \geq 25mm	0=No,
<input type="checkbox"/>	S \geq 25mm	
<input type="checkbox"/>	R or S \geq 30mm	1=Yes,
<input type="checkbox"/>	R + S \geq 35mm	
<input type="checkbox"/>	Intrinsicoid deflection \geq.05 sec	9=Fully paced, Complete LBBB or Unk
<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 Unk.)	
<input type="checkbox"/>	Nonspecific T-wave abnormality (0=No, 1=T inversion, 2=T flattening, 3=Other, 9=Fully paced or Unk.)	
<input type="checkbox"/>	U-wave present (0=No, 1=Yes, 2=Maybe, 9=Paced or Unk.)	
<input type="checkbox"/>	Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unk.)	
<input type="checkbox"/>	RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.; If complete RBBB OR LBBB 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 Unk., If complete LBBB present, LVH=9)	

Comments _____

MD25

Clinical Diagnostic Impression--Part I

Heart Diagnoses		
<input type="checkbox"/>	Rheumatic Heart Disease	0=No,
<input type="checkbox"/>	Aortic Valve Disease	1=Yes,
<input type="checkbox"/>	Mitral Valve Disease	2=Maybe,
<input type="checkbox"/>	Arrhythmia	9=Unk.
<input type="checkbox"/>	Other Heart Disease (includes congenital)	
(Specify) _____		


Peripheral Vascular Disease		
<input type="checkbox"/>	Other Peripheral Vascular Disease	0=No,
<input type="checkbox"/>	Other Vascular Diagnosis	1=Yes,
(Specify) _____		
2=Maybe,		
9=Unk.		

Neurological Disease		
<input type="checkbox"/>	Stroke/ TIA	0=No,
<input type="checkbox"/>	Dementia	1=Yes,
<input type="checkbox"/>	Parkinson's Disease	2=Maybe,
<input type="checkbox"/>	Adult Seizure Disorder	9=Unk.
<input type="checkbox"/>	Migraine	
<input type="checkbox"/>	Other Neurological Disease	
(Specify) _____		

Comments _____

MD26

Clinical Diagnostic Impression--Part II. Non Cardiovascular Diagnoses

Endocrine		
<input type="checkbox"/>	Thyroid Disease	0=No, 1=Yes,
<input type="checkbox"/>	Diabetes Mellitus	2=Maybe,
<input type="checkbox"/>	Other endocrine disorders, specify _____	9=Unk.
GU/GYN		
<input type="checkbox"/>	Renal disease, specify _____	0=No, 1=Yes,
<input type="checkbox"/>	Prostate disease	2=Maybe,
<input type="checkbox"/>	Gynecologic problems, specify _____	8=male/female 9=Unk.
Pulmonary		
<input type="checkbox"/>	Emphysema	0=No,
<input type="checkbox"/>	Pneumonia	1=Yes,
<input type="checkbox"/>	Asthma	2=Maybe,
<input type="checkbox"/>	Other pulmonary disease, specify _____	9=Unk.
Rheumatologic Disorders		
<input type="checkbox"/>	Gout	0=No,
<input type="checkbox"/>	Degenerative joint disease	1=Yes,
<input type="checkbox"/>	Rheumatoid arthritis	2=Maybe,
<input type="checkbox"/>	Other musculoskeletal or connective tissue disease, specify _____	9=Unk.
GI		
<input type="checkbox"/>	Gallbladder disease	0=No,
<input type="checkbox"/>	GERD/ulcer disease	1=Yes,
<input type="checkbox"/>	Liver disease	2=Maybe,
<input type="checkbox"/>	Other GI disease, specify _____	9=Unk.
Blood		
<input type="checkbox"/>	Hematologic disorder	0=No, 1=Yes,
<input type="checkbox"/>	Bleeding disorder	2=Maybe, 9=Unk
Infectious Disease		
<input type="checkbox"/>	Infectious Disease	0=No, 1=Yes,
if yes 	specify _____	2=Maybe, 9=Unk
Mental Health		
<input type="checkbox"/>	Depression	0=No,
<input type="checkbox"/>	Anxiety	1=Yes,
<input type="checkbox"/>	Other Mental health, specify _____	2=Maybe, 9=Unk.
Other		
<input type="checkbox"/>	Eye	0=No, 1=Yes,
<input type="checkbox"/>	ENT	2=Maybe,
<input type="checkbox"/>	Skin	9=Unk.
<input type="checkbox"/>	Other, specify _____	

Comments

Second Examiner Opinions

_ _ _	2nd Examiner ID number _____	2nd Examiner Last Name _____
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Coronary Heart Disease			
(Provide initiators, qualities, radiation, severity, timing, presence after procedures done)			
Item requires 2nd opinion <i>Check ALL that apply.</i>	2nd opinion		
<input type="checkbox"/>	_	Congestive Heart Failure	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	_	Cardiac Syncope	
<input type="checkbox"/>	_	Angina Pectoris	
<input type="checkbox"/>	_	Coronary Insufficiency	
<input type="checkbox"/>	_	Myocardial Infarct	

Comments about heart disease _____

Intermittent Claudication			
(Provide initiators, qualities, radiation, severity, timing, presence after procedures done)			
Item requires 2nd opinion <i>Check ALL that apply.</i>	2nd opinion		
<input type="checkbox"/>	_	Intermittent Claudication	0=No, 1=Yes, 2=Maybe, 9=Unk.

Comments about peripheral artery disease _____

Cerebrovascular Disease			
(Provide initiators, qualities, severity, timing, presence after procedures done)			
Item requires 2nd opinion <i>Check ALL that apply.</i>	2nd opinion		
<input type="checkbox"/>	_	Stroke	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	_	TIA	

Comments about possible cerebrovascular disease _____

MD28

