

Numerical Data (Anthropometry)

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Technician Number.
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Basic Information	
<i>Check Protocol Modification ONLY if there was one and document it in Comment section</i>	
<input type="checkbox"/>	Marital Status (1=Single, 2=Married, 3=Widowed, 4=Divorced, 5=Separated)
<input type="checkbox"/>	Site of Exam (0=Heart Study, 1=Nursing home, 2=Residence, 3=Other, 9=Unk.)
<input type="text"/>	Weight (to nearest pound, 999=Unk.)
	<input type="checkbox"/> Protocol modification for weight (check if Yes)
if not FHS protocol fill	Method used to obtain weight, if not FHS protocol or field visit with portable scale (1=recorded in NH chart, 2=Other write in _____)
	<input type="text"/> * <input type="text"/> * <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date weight obtained (99/99/9999=Unk.) <i>if not Exam date</i>
<input type="text"/> * <input type="text"/>	Height (inches, to next lower 1/4 inch, 99/99=Unk.) 88/88=field visit
	<input type="checkbox"/> Protocol modification for height. (check if Yes)

<p>Comments on all protocol modifications:</p> <hr/> <hr/> <hr/> <hr/>

TECH01

Check here if whole page is blank. Reason why _____

Technician Number.

EXAM 30 Procedures Sheet

<input type="checkbox"/>	ECG	
<input type="checkbox"/>	Physician Medical History (Tech. Medical History, off-site)	
<input type="checkbox"/>	Observed Physical Performance	0=No
<input type="checkbox"/>	CES-D	
<input type="checkbox"/>	MMSE	1=Yes
<input type="checkbox"/>	Berkman Social Network	
<input type="checkbox"/>	Physical function: Katz, Rosow-Breslau, Nagi, IADL	
<input type="checkbox"/>	Leisure Time Cognitive and Physical Activities	9=Unk.
<input type="checkbox"/>	Height	8=not done due to offsite visit
<input type="checkbox"/>	Weight	
<input type="checkbox"/>	Socio-demographic, Nursing (Community) Services Use	

Adverse Events

Technician ID#

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

Was a FHS physician contacted during the offsite examination due to medical concern? (0=No, 1=Yes, 9=Unk.) (offsite exam only)
Comments: _____

Exit Interview

Technician ID

<input type="checkbox"/>	Procedure Sheet Review	
<input type="checkbox"/>	Referral Sheet Review	0=No
<input type="checkbox"/>	Left Clinic with all belongings 8=n/a, offsite	
<input type="checkbox"/>	Feedback 0=No feedback, 1=Positive feedback, 2=Negative feedback, 3=Other	1=Yes

Comments _____

TECH02

Observed performance. Part 1 Technician Administered

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
<input type="checkbox"/>	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?		
<input type="checkbox"/> 1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.		

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

TECH03

Observed performance. Part 2 Technician Administered

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

Measured Walks	
Course in meters. <u>OFFSITE ONLY</u> (check one)	<input type="checkbox"/> 3m <input type="checkbox"/> 4m
First Walk	
Walk time (in seconds, 99.99=Unk.)	<input type="text"/> * <input type="text"/>
Walking aid used: (0=No aid, 1=Cane, 2=Walker, 3=Other, 9=Unk.)	<input type="text"/>
<input type="checkbox"/> Check if this test not completed or not attempted.	
<input type="checkbox"/> If not attempted or completed, why not? (1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.)	
Second Walk	
Walk time (in seconds, 99.99=Unk.)	<input type="text"/> * <input type="text"/>
<input type="checkbox"/> Check if this test not completed or not attempted.	
<input type="checkbox"/> If not attempted or completed, why not? (1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.)	
Quick Walk	
Walk time (in seconds, 99.99=Unk.)	<input type="text"/> * <input type="text"/>
<input type="checkbox"/> Check if this test not completed or not attempted.	
<input type="checkbox"/> If not attempted or completed, why not? (1=Physical limitation, 2=Refused, 3=Other _____ write in, 9=Unk.)	

TECH04

Mini-Mental State Exam

_	Check here if whole page is blank.	Reason why _____
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Read Script: I'm going to ask some questions that require concentration and memory. Some questions are more difficult than others and some will be asked more than one time.

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

TECH05

Mini-Mental State Exam

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

0=No, 1=Yes, 2=Maybe, 9=Unk	Factor Potentially Affecting Mental State Testing
0 1 2 9	Illiterate or low education
0 1 2 9	Poor eyesight
0 1 2 9	Poor hearing
0 1 2 9	Depression / possible depression
0 1 2 9	Other

TECH06

Socio-demographics

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
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<input type="text"/>	Technician Number for Socio-demographics
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Socio-demographics	
<input type="checkbox"/>	Where do you live? (0=Private residence, 1=Nursing home, 2=Other institution, such as: assisted living or retirement community, 9=Unk.)
<input type="checkbox"/>	Does anyone live with you? (0=No, 1=Yes, 9=Unk.) Code Nursing Home Residents as NO to these questions
If Yes If 0 or 9, skip down	<input type="checkbox"/> Spouse
	<input type="checkbox"/> Children
	<input type="checkbox"/> Other Relatives
<input type="checkbox"/>	Are you Currently working at a paying job or doing unpaid volunteer or community work? (0=No,1=Yes.)
<input type="text"/>	During the past 6 months (180 days) how many days were you so sick that you were unable to carry out your usual activities? (999=Unk.)

** Proxy may NOT be used to help complete this section **	
<input type="checkbox"/>	In general, how is your health now: (1=Excellent, 2=Good, 3=Fair, 4=Poor, 9=Unkn)
<input type="checkbox"/>	Compare your health to most people your own age: (1=Better, 2=About the same, 3=Worse than most people your own age, 9=Unk.)
<input type="checkbox"/>	As I get older, things are: (1= Better than I thought they'd be, 2=About the same that I thought they'd be, 3= Worse, 9=Unk.)

TECH07

Instrumental Activities of Daily Living (Lawton IADL)*(Not administered to nursing home residents)*

_ _	Check here if whole page is blank.	Reason why _____
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Instructions: Use the prompt cards when asking these questions. **If code=2** –write in definition of “some help”

_ _	1. Can you use the phone: 01 completely unable to use the phone 02 with some help 03 without help (operates phone on own initiative, looks up, dials number, etc.)
_ _	2. Can you get to places out of walking distance: 01 completely unable to travel unless special arrangements are made (taxi or car with human assistance) 02 with some help (when assisted or accompanied by another) 03 without help (travels independently: drives car, public transportation or use of taxi)
_ _	3. Can you go shopping for groceries : 01 completely unable to do any shopping 02 with some help (needs to be accompanied on any shopping trip) 03 without help 88 resides in assisted living facility, does not do
_ _	4. Can you prepare your own meals: 01 completely unable to prepare meals (needs meals prepared and served) 02 with some help (heat and serve prepared meals) 03 without help (plans, prepares, serves meals) 88 resides in assisted living facility, does not do
_ _	5. Can you do your own housework : 01 completely unable to do any housework 02 with some help 03 without help (performs light daily tasks – dishwashing, bed making, etc). 88 resides in assisted living facility, does not do
_ _	6. Can you do your own handyman work: 01 completely unable to do any handyman work 02 with some help 03 without help 88 resides in assisted living facility, does not do
_ _	7. Can you do your own laundry: 01 completely unable to use the laundry 02 with some help (such as using laundry service) 03 without help (does personal laundry completely) 88 resides in assisted living facility, does not do
_ _	8. A. Do you take medicines or use any medications: 01 Yes <i>Go to question 8B</i> 02 No <i>Go to question 8C</i>
_ _	8. B. Do you take your own medicines: 01 completely unable to take own medicine 02 with some help (if someone prepares it or reminds you) 03 without help (in the right doses at the right time)
_ _	8. C. If you had to take medicine, could you do it: 01 completely unable to take own medicine 02 with some help (if someone prepares it or reminds you) 03 without help (in the right doses at the right time)
_ _	9. Can you manage your own money: 01 completely unable to manage own money 02 with some help (manages day-to-day purchases, needs help with banking, major purchases) 03 without help

TECH08

Self-Reported Physical Function.

<input type="checkbox"/> Check here if whole page is blank.	Reason why _____
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Note: If the participant is unable to answer the Nagi & Rosow-Breslau questions, Proxy may answer these questions.

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Technician Number for Rosow-Breslau and Nagi Quest.
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Nagi Questions

For each thing tell me whether you have

- (0) No Difficulty
- (1) A Little Difficulty
- (2) Some Difficulty
- (3) A Lot Of Difficulty
- (4) Unable To Do
- (5) Don't Do On MD Orders or Institutional Orders
- (6) Unable to Assess Difficulty Because Not Done as Part of Daily Activities
- (9) Unk.

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Pulling or pushing large objects like a living room chair |
| <input type="checkbox"/> | Either stooping, crouching, or kneeling |
| <input type="checkbox"/> | Reaching or extending arms below shoulder level |
| <input type="checkbox"/> | Reaching or extending arms above shoulder level |
| <input type="checkbox"/> | Either writing, or handling or fingering small objects |
| <input type="checkbox"/> | Standing in one place for long periods, say 15 minutes |
| <input type="checkbox"/> | Sitting for long periods, say 1 hour |
| <input type="checkbox"/> | Lifting or carrying weights under 10 pounds (like a bag of potatoes) |
| <input type="checkbox"/> | Lifting or carrying weights over 10 pounds (like a very heavy bag of groceries) |

Rosow-Breslau Questions

- | | | |
|--------------------------|---|--------------------|
| <input type="checkbox"/> | Are you able to do heavy work around the house, like shoveling snow or washing windows, walls, or floors without help? | 0=No, unable to do |
| <input type="checkbox"/> | Are you able to walk half a mile without help? (About 4-6 blocks) | 1=Yes, able |
| <input type="checkbox"/> | Are you able to walk a quarter of a mile without help? (About 2-3 blocks) | 2=Does not do |
| <input type="checkbox"/> | Are you able to walk up and down stairs to the second floor without any help? | 9=Unk. |
| <input type="checkbox"/> | Are you able to climb up 10 steps without help? | |
| <input type="checkbox"/> | Do you drive now? (0=No, 1=Yes, 9=Unk) | |
| <input type="checkbox"/> | Reason for <u>not</u> driving now (1=Health, 2=Other non-health reason, 3=never licensed, 9=Unk.) | |

TECH09

Self-Reported Physical Function.

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
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<input type="checkbox"/>	Technician Number for Physical Function
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Katz: Activities of Daily Living

During the Course of a Normal Day, can you do the following activities independently or do you need help from another person or use special equipment or a device?.

(0=No help needed, independent, 1=Uses device, independent, 2=Human assistance needed, minimally dependent, 3=Dependent, 4=Do not do during a normal day, 9=Unk.)

Dressing (undressing and redressing) *Devices such as: velcro, elastic laces.*

Bathing (including getting in and out of tub or shower) *Devices such as: bath chair, long handled sponge, hand held shower, safety bars.*

Eating *Devices such as: rocking knife, spork, long straw, plate guard.*

Transferring(getting in and out of a chair) *Devices such as: sliding board, grab bars, special seat.*

Toileting Activities (using bathroom facilities and handle clothing) *Devices such as: special toilet seat, commode.*

Bladder Continence (ask if person has "accidents"; code=5 if use special products) *Devices such as: external catheter, drainage bags, ileal appliance, protective devices.*

Bowel Continence (ask if person has "accidents") (code=5 if use special products) *Devices such as: suppositories, bedpan, regular enemas, colostomy.*

Walking on Level Surface about 50 Yards *Devices such as: cane, crutches, or walker.*

Walking up and down One Flight Stairs *Devices such as: handrail, cane.*

TECH10

Activities Questions.

<input type="checkbox"/>	Check here if whole page is blank.	Reason why _____
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<input type="text"/>	Technician Number for Activities Questions
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Use of Nursing and Community Services	
<input type="checkbox"/>	Have you been admitted to a nursing home (or skilled facility) since your last exam or medical history update? (0=No, 1=Yes, 9=Unk.)
<input type="checkbox"/>	Since your last exam, have you been visited by a nursing service, or used home, community, or outpatient programs? (0=No, 1=Yes, 9=Unk.)
if yes, check all services ☞	<input type="checkbox"/> Home health aides
	<input type="checkbox"/> Homemaker visits
	<input type="checkbox"/> Visiting Nurses
	<input type="checkbox"/> Other (write in) _____

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

TECH11

Falls and Fractures

_	Check here if whole page is blank.	Reason why _____
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_ _ _	Technician Number for Falls and Fractures
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_	if yes, fill ☞	<p>Since your last exam have you accidentally fallen and hit the floor or ground? <i>(code as no if during sports activity) (0=No, 1=Yes, 2=Maybe, 9=Unk)</i></p>
_ _		<p>How many times did you fall in the past year? <i>(99=Unk.)</i></p>

_	If 1 or 2, fill ☞	<p>Since your last exam or medical history update have you broken any bones? <i>(0=No, 1=Yes, 2=Maybe, 9=Unk.)</i></p>
_ _		Location of 1st fracture
_ _		Location of 2nd fracture
_ _		Location of 3rd fracture

- | Location Fracture Code |
|---|
| 1. Clavicle (collar bone) |
| 2. Upper arm (humerus) or elbow |
| 3. Forearm or wrist |
| 4. Hand |
| 5. Back (If disc disease only, code as no) |
| 6. Pelvis |
| 7. Hip |
| 8. Leg |
| 9. Foot |
| 10. Other (specify) _____ |

TECH12

Berkman Social Network Questionnaire. Tech-administered

_	Check here if whole page is blank.	Reason why _____
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The next questions ask about your social support. Please tell me the response that most closely describes your current situation.

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

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

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

TECH13

**Berkman Social Network Questionnaire
Tech- Administered**

Check here if whole page is blank. Reason why _____

7. Do you have health insurance other than Medicare or Medicaid? (0=No, 1=Yes, 9=Ukn.)

For each question please circle one answer

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

TECH14

Leisure Time Cognitive and Physical Activities

Check here if whole page is blank. Reason why _____

Technician Number for Leisure time activities.

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

<i>Questions to be answered</i> <i>Circle best answer for each question</i>	Never	Daily <small>(7 days per week)</small>	Several days per week <small>(2-6 days per week)</small>	Once weekly <small>(1 day per week)</small>	Monthly <small>(once a month)</small>	Occasionally <small>(< once a month)</small>	Unk.
1. Reading books/newspapers	0	1	2	3	4	5	9
2. Writing for pleasure	0	1	2	3	4	5	9
3. Doing crossword puzzles	0	1	2	3	4	5	9
4. Playing board games or cards	0	1	2	3	4	5	9
5. Participating in organized group discussions	0	1	2	3	4	5	9
6. Group exercises	0	1	2	3	4	5	9
7. Housework	0	1	2	3	4	5	9
8. Playing musical instruments	0	1	2	3	4	5	9

TECH15

CES-D Scale

_ _ Check here if whole page is blank.	Reason why _____
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_ _ _ Technician Number for CES-D Scale

The next questions ask about your feelings. For each of the following statements, please say if 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

TECH16

Proxy form

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

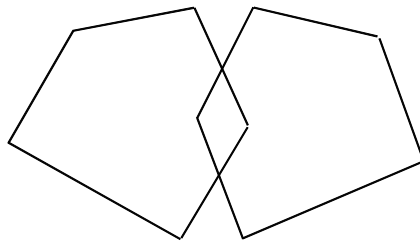
TECH17

Mini-Mental State Exam

Sentence and Design Handout for Participant

PLEASE WRITE A SENTENCE

PLEASE COPY THIS DESIGN



Date of exam

____/____/____

**Framingham Heart Study
Cohort Exam 30****Summary Sheet to Personal Physician**

Blood Pressure	First Reading	Second Reading
Systolic		
Diastolic		

ECG Diagnosis _____
_____**Summary of Findings** _____

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

Comment: Back of letter to physician--Intentionally blank

Referral Tracking

Check here if whole page is blank. Reason why _____

<input type="checkbox"/> 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).
<input type="checkbox"/> Blood Pressure result ____/____ mmHg	SBP or DBP Phone call ≥ 200 or ≥ 110 Expedite ≥ 180 or ≥ 100 Elevated ≥ 140 or ≥ 90
Write in abnormality	
<input type="checkbox"/> ECG abnormality _____	
<input type="checkbox"/> Clinic Physician identified medical problem _____	
<input type="checkbox"/> Other _____	

Method used to inform participant of need for further medical evaluation (Check ALL that apply)	
<input type="checkbox"/>	Face-to-face in clinic
<input type="checkbox"/>	Phone call
<input type="checkbox"/>	Result letter
<input type="checkbox"/>	Other

Method used to inform participant's personal physician of need for further medical evaluation (Check ALL that apply)	
<input type="checkbox"/>	Phone call
<input type="checkbox"/>	Result letter mailed
<input type="checkbox"/>	Result letter FAX'd (inform staff if Fax needed)
<input type="checkbox"/>	Other

Date referral made: ____/____/____

ID number of person completing the referral: _____

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

REF1

Medical History—Hospitalizations, ER Visits, MD Visits

Cohort Exam30

DATE _____

DATE of last exam 01/01/2000

DATE of last health update No MHU

Health Care	
Since your last exam or health 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.)
_ _ _ _ _ _ _ _	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

Hypertension

Since your last exam have you taken medication for the treatment of hypertension? (**high blood pressure**)
(0=No, 1=Yes, now, 2=Yes, not now, 9=Unk)

Aspirin use

Take aspirin regularly? (0=No, 1=Yes, 9=Unk)

If yes,

fill 

Number of aspirins taken regularly (99=Unk.)

Aspirin frequency- number taken regularly (0=Never, 1=Day, 2=Week, 3=Month, 4=Year, 9=Unk)

Usual dose (write in mgs, 999=Unk.) Examples: 081=baby, 160=half dose, 250=like in Excedrin , 325=usual dose, 500=extra strength

MD02

Medical History–Blood Pressure, Smoking

Blood Pressure (first reading)	
Systolic	BP cuff size
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unk.	<input type="text"/> 0=pediatric, 1=regular adult, 2=large adult, 3= thigh, 9=Unk.
Diastolic	Protocol modification
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unk.	<input type="text"/> 0=No, 1=Yes, 9=Unk. write in _____

Smoking	
<input type="text"/> if yes fill	Have you smoked cigarettes regularly since your last exam? 0=No, 1=Yes, now, 2=Yes, not now, 9=Unk.
<input type="text"/> <input type="text"/> <input type="text"/>	How many cigarettes do/did you smoke a day? (01=one or less, 99=Unk.)

MD05

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	
What is your average number of servings in a typical week or month since your last exam? (999=Unk.) <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)	_ _ _	_ _ _

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

MD06

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? (<i># of years.</i>)
	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? (<i># of years</i>)
	1=1 year or less 99=Unk

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?

MD07

Medical History—Respiratory Symptoms. Part 2

Nocturnal chest symptoms (0=No, 1=Yes, 9=Unk.)

In the past 12 months...

Have you been awakened by shortness of breath?

Have you been awakened by a wheezing/whistling in your chest?

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.

Shortness of breath (0=No, 1=Yes, 9=Unk.)

Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?

if yes, fill all **Do you have to walk slower than people of your age on level ground because of shortness of breath?**

Do you have to stop for breath when walking at your own pace on level ground?

Do you have to stop for breath after walking 100 yards (or after a few minutes) on level ground?

Do you/have you needed to sleep on two or more pillows to help you breathe (Orthopnea)?

Have you since last exam had swelling in both your ankles (ankle edema)?

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.

Have you been hospitalized for heart failure?

if yes, fill **Name of hospital** _____

Date of visit ** 99/99/9999=Unk.

Examiner Opinion

First examiner believes CHF 0=No,1=Yes
2=Maybe, 9=Unk.

Comments _____

MD08

Medical History—Heart

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

MD09

Medical History—Heart (Continued)

<input type="checkbox"/>	Have you since your last exam been told by doctor you have/had a heart attack or myocardial infarction? (0=No, 1=Yes, 2=Maybe, 9=Unknown)
if yes, fill	Name of doctor _____
	Date of visit __ _ * __ _ * __ _ _ _ 99*99*9999=Unk.
<input type="checkbox"/>	Have you been hospitalized for heart attack?
if yes, fill	Name of hospital _____
	Date of visit __ _ * __ _ * __ _ _ _ 99*99*9999=Unk.

CHD First Opinions	
<input type="checkbox"/>	Angina pectoris in interim
<input type="checkbox"/>	Angina pectoris since revascularization procedure
<input type="checkbox"/>	Coronary insufficiency in interim
<input type="checkbox"/>	Myocardial infarct in interim

0=No,
1=Yes,
2=Maybe,
9=Unk.

Comments _____

MD10

Medical History—Atrial Fibrillation/Syncope

<input type="checkbox"/>	Have you been told you have/had a heart rhythm problem called atrial fibrillation? (0=No, 1=Yes, 2=Maybe, 9=Unk.)																				
if yes, fill	<table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td colspan="10">Date of first episode (99/99/9999=Unk.)</td> </tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Date of first episode (99/99/9999=Unk.)									
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>												
Date of first episode (99/99/9999=Unk.)																					
<input type="checkbox"/>	ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unk.)																				
	Hospitalized at: _____																				
	M.D. seen: _____																				

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

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

Comments _____

MD11

Medical History—Cerebrovascular Disease

Cerebrovascular Episodes in Interim		
<input type="checkbox"/>	Sudden muscular weakness	
<input type="checkbox"/>	Sudden speech difficulty	0=No,
<input type="checkbox"/>	Sudden visual defect	1=Yes,
<input type="checkbox"/>	Sudden double vision	2=Maybe,
<input type="checkbox"/>	Sudden loss of vision in one eye	9=Unk.
<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,
<input type="checkbox"/>	Have you been told by a doctor you have Parkinson Disease?	1=Yes,
<input type="checkbox"/>	Have you been told by a doctor you have memory problems, dementia or Alzheimer's disease?	2=Maybe,
<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?	9=Unk.

Comments: _____

MD12

Medical History—Cerebrovascular Disease Continued

Details for "Serious" Cerebrovascular Event in Interim

<input type="checkbox"/> if yes or maybe fill all	Examiner's opinion that TIA or stroke took place in interim (0=No, 1=Yes, 2=Maybe, 9=Unk.)	
	<input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date (mo/yr, 99/9999=Unk.) Observed by _____
	<input type="checkbox"/> <input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/>	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) Name _____ Address _____

Neurology First Opinions

<input type="checkbox"/>	Stroke in Interim	
<input type="checkbox"/>	TIA	0=No, 1=Yes, 2=Maybe, 9=Unk.
<input type="checkbox"/>	Dementia	
<input type="checkbox"/>	Parkinson Disease	
<input type="checkbox"/>	Other, Specify: _____	

Comments _____

MD13

Medical History--Peripheral Arterial Disease

Peripheral Arterial Disease			
<input type="checkbox"/>	Are you able to walk 50 feet without help? (0=Able to walk 50 feet without help, 1=Needs help, 2=Can't walk, 9=Unknown)		
<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"/> <input type="checkbox"/> <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"/>	After walking a while.		
<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?		
What do you do if you get discomfort when you are walking? <i>Check one below</i>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1=stop	2=slow down	3=continue at same pace	9=Unk.
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Time for discomfort to be relieved by stopping (minutes) (000=No relief with stopping, 999=Unk.)		
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Number of days/month of lower limb discomfort (1=1 day/month or less, 99=Unk.)		

MD14

Medical History--Peripheral Arterial Disease Continued

<input type="checkbox"/>	Since your last exam have you been told you have intermittent claudication or peripheral artery disease? (0=No, 1=Yes, 2=Maybe, 9=Unk.)
if yes, fill	Name of doctor _____
	Date of visit __ _ * __ _ * __ _ _ _ _
<input type="checkbox"/>	Have you been hospitalized for intermittent claudication or peripheral artery disease? (0=No, 1=Yes, 2=Maybe, 9=Unk.)
if yes, fill	Name of hospital _____
	Date of visit __ _ * __ _ * __ _ _ _ _

PAD First Opinions	
<input type="checkbox"/>	Intermittent Claudication <div style="float: right; font-size: small;"> 0=No, 1=Yes, 2=Maybe, 9=Unk. </div>

Comments _____

MD15

Venous Disease and Second Blood Pressure

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

Blood Pressure (second reading)	
Systolic	BP cuff size
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unk.	<input type="text"/> 0=pediatric, 1=regular adult, 2=large adult, 3= thigh, 9=Unk.
Diastolic	Protocol modification
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unk.	<input type="text"/> 0=No, 1=Yes, 9=Unk. write in _____

Comments on Protocol modification

MD16

Medical History-- CVD Procedures

Since your last exam or health 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 _____

Comments: _____

MD17

Cancer Site or Type

Since your last exam or health update have you had a cancer or a tumor?
 (0=No and skip to **MD19** (next screen); 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 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)

MD18

Electrocardiograph--Part I

<input type="text"/>	Examiner ID Number _____	Examiner Last Name _____
<input type="checkbox"/> if Yes, fill out rest of form	ECG done (0=No, 1=Yes)	
Rates and Intervals		
<input type="text"/>	Ventricular rate per minute (999=Unk.)	
<input type="text"/>	P-R Interval (milliseconds) (999=Fully Paced, Atrial Fib, or Unk.)	
<input type="text"/>	QRS interval (milliseconds) (999=Fully Paced, Unk.)	
<input type="text"/>	Q-T interval (milliseconds) (999=Fully Paced, Unk.)	
<input type="text"/>	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		
<input type="checkbox"/>	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		
<input type="checkbox"/>	IV Block (0=No, 1=Yes, 9=Fully paced or Unk.)	
	<input type="checkbox"/> Pattern (1=Left, 2=Right, 3=Indeterminate, 9=Unk.)	
if yes, fill <input type="checkbox"/>	<input type="checkbox"/> Complete (QRS interval=.12 sec or greater)(0=No, 1=Yes, 9=Unk.)	
	<input type="checkbox"/> Incomplete (QRS interval = .10 or .11 sec) (0=No, 1=Yes, 9=Unk.)	
<input type="checkbox"/>	Hemiblock (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unk.)	
<input type="checkbox"/>	WPW Syndrome (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.)	
Arrhythmias		
<input type="checkbox"/>	Atrial premature beats (0=No, 1=Atr, 2=Atr Aber, 9=Unk.)	
<input type="checkbox"/>	Ventricular premature beats (0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)	
<input type="text"/>	Number of ventricular premature beats in 10 seconds (see 10 second rhythm strip, 99=Unk.)	

MD19

Electrocardiograph-Part II

Myocardial Infarction Location	
<input type="checkbox"/>	Anterior (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.)
<input type="checkbox"/>	Inferior
<input type="checkbox"/>	True Posterior
Left Ventricular Hypertrophy Criteria	
<input type="checkbox"/>	R > 20mm in any limb lead (0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)
<input type="checkbox"/>	R > 11mm in AVL
<input type="checkbox"/>	R in lead I plus S ≥ 25mm in lead III
Measured Voltage	
* <input type="checkbox"/>	R AVL in mm (at 1 mv = 10 mm standard) <i>Be sure to code these voltages</i>
* <input type="checkbox"/>	S V3 in mm (at 1 mv = 10 mm standard) <i>Be sure to code these voltages</i>
R in V5 or V6-----S in V1 or V2	
<input type="checkbox"/>	R ≥ 25mm
<input type="checkbox"/>	S ≥ 25mm
<input type="checkbox"/>	R or S ≥ 30mm (0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)
<input type="checkbox"/>	R + S ≥ 35mm
<input type="checkbox"/>	Intrinsicoid deflection ≥ .05 sec
<input type="checkbox"/>	S-T depression (strain pattern)
Hypertrophy, enlargement, and other ECG Diagnoses	
<input type="checkbox"/>	Nonspecific S-T segment abnormality (0=No, 1=S-T depression, 2=S-T flattening, 3=Other, 9=Fully paced or 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 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 and Diagnosis _____

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Clinical Diagnostic Impression.

Non Cardiovascular Diagnoses First Examiner Opinions	
<input type="checkbox"/> Diabetes Mellitus	
<input type="checkbox"/> Prostate disease	
<input type="checkbox"/> Renal disease (specify)_____	
<input type="checkbox"/> Emphysema	
<input type="checkbox"/> Chronic bronchitis	0=No,
<input type="checkbox"/> Pneumonia	1=Yes,
<input type="checkbox"/> Asthma	2=Maybe,
<input type="checkbox"/> Other pulmonary disease	9=Unk.
<input type="checkbox"/> Gout	
<input type="checkbox"/> Degenerative joint disease	
<input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/> Gallbladder disease	
<input type="checkbox"/> Other non C-V diagnosis (for cancer, see special screen)	

**Comments CDI Other
Diagnoses**

Continue Comments on the next page→

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