Numerical Data (Anthropometry)

|__| Check here if whole page is blank. Reason why______________________________________

|__|__|__| **Technician Number**.

Basic Information *Check* ***Protocol Modification*** *ONLY if there was one and document it in Comment section*		
|__|	**Marital Status** (1=Single, 2=Married, 3=Widowed, 4=Divorced, 5=Separated)	
|__|	**Site of Exam** (0=Heart Study, 1=Nursing home, 2=Residence, 3=Other, 9=Unk.)	
|__|__|__|	**Weight** (*to nearest pound*, 999=Unk.)	
	|__|	**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 ____)
	|__|__|*|__|__|*|__|__|__|__|	**Date weight obtained** (99/99/9999=Unk.) *if not Exam date*
|__|__|*|__|__|	**Height** (*inches, to next lower* 1/4 inch, 99/99=Unk.) 88/88=field visit	
	|__|	**Protocol modification for height.** *(check if Yes)*

Comments on all **protocol modifications:**

____

____

____

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TECH01

|__| Check here if whole page is blank. Reason why______________________________________

|__|__|__| **Technician Number**.

EXAM 30 Procedures Sheet

|__|	**ECG**	
|__|	**Physician Medical History (Tech. Medical History, off-site)**	
|__|	**CES-D**	
|__|	**MMSE**	1=Yes
|__|	**Berkman Social Network**	
|__|	**Physical function: Katz, Rosow-Breslau, Nagi, IADL**	
|__|	**Leisure Time Cognitive and Physical Activities**	9=Unk.
|__|	**Height** 8=not done due to offsite visit	
|__|	**Weight**	
|__|	**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**

|__|	**Procedure Sheet Review**	0=No
|__|	**Referral Sheet Review**	
|__|	**Left Clinic with all belongings** 8=n/a, offsite	1=Yes
|__|	**Feedback** 0=No feedback, 1=Positive feedback, 2=Negative feedback, 3=Other	

Comments____

____

____

TECH02

Mini-Mental State Exam

|__| Check here if whole page is blank. Reason why____________________________________

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**

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?**

TECH03

Mini-Mental State Exam

|__| Check here if whole page is blank. Reason why______________________________

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

Socio-demographics

|__| Check here if whole page is blank. Reason why_______________________________________

|__|__|__|	**Technician Number** for Socio-demographics

Socio-demographics		
|__|	**Where do you live?** (0=Private residence, 1=Nursing home, 2=Other institution, such as: assisted living or retirement community, 9=Unk.)	
|__|	**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**	|__| Spouse	0=No 1=Yes, less than 3 months per year 2=Yes, at least 3 months per year 9=Unk.
	|__| Children	
	|__| Other Relatives	
|__|	**Are you Currently working at a paying job or doing unpaid volunteer or community work?** (0=No,1=Yes.)	
|__|__|__|	**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* **	
|__|	**In general, how is your health now**: (1=Excellent, 2=Good, 3=Fair, 4=Poor, 9=Unkn)
|__|	**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.)
|__|	**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.

TECH05

Instrumental Activities of Daily Living (Lawton IADL)

(Not administered to nursing home residents)

|__| Check here if whole page is blank. Reason why______________________________________

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 *Go to question* **8B**
	02	No *Go to question* **8C**
|__|__|	**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

TECH06

Self-Reported Physical Function.

|__| Check here if whole page is blank. Reason why______________________________________

Note: *If the participant is unable to answer the Nagi & Rosow-Breslau questions, Proxy may answer these questions.*

|__|__|__|	**Technician Number** for Rosow-Breslau and Nagi Quest.

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.

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

Rosow-Breslau Questions

Codes: 0=No, unable to do; 1=Yes, able; 2=Does not do; 9=Unk.

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

TECH07

Self-Reported Physical Function.

|__| Check here if whole page is blank.	Reason why____________________________________

|__|__|__|	**Technician Number** for Physical Function

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*.

Falls

|__|	**Since your last exam have you accidentally fallen and hit the floor or ground?** *(code as no if during sports activity)* (0=No, 1=Yes, 2=Maybe, 9=Unk)	
if yes, fill ☞	|__|__|	**How many times did you fall in the past year?** (99=Unk.)

TECH08

Activities Questions.

|__| Check here if whole page is blank. Reason why____________________________________

|__|__|__| **Technician Number** for Activities Questions

Use of Nursing and Community Services

|__|	**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.)	
|__|	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 ☞	|__|	**Home health aides**
	|__|	**Homemaker visits**
	|__|	**Visiting Nurses**
	|__|	**Other** (write in)____

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

TECH09

Berkman Social Network Questionnaire. Tech-administered

|__| Check here if whole page is blank.	Reason why_______________________________
|__|__|__|	**Technician Number** for Berkman Questionnaire.

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

For each question please circle one answer						
Coding scheme	**None**	**1 or 2**	**3 to 5**	**6 to 9**	**10 or more**	**Unk.**
1. How many *close friends* 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 *close friends* do you see at least once a month?	**0**	**1**	**2**	**3**	**4**	**9**
3. How many *relatives* 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 *relatives* do you see at least once a month?	**0**	**1**	**2**	**3**	**4**	**9**

For each question please circle one answer						
Coding Scheme	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**	**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**

TECH10

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?

Questions to be answered *Circle best answer for each question*	Never	Daily (7 days per week)	Several days per week (2-6 days per week)	Once weekly (1 day per week)	Monthly (once a month)	Occasionally (< once a month)	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

TECH11

CES-D Scale

|__| Check here if whole page is blank. Reason why____

|__|__|__| **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.

	Circle best answer for each question			
DURING THE PAST WEEK	**Rarely or none of the time (less than 1 day)**	**Some or a little of the time (1-2 days)**	**Occasionally or moderate amount of time (3-4 days)**	**Most or all of the time (5-7 days)**
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

TECH12

Proxy form

|__|	**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** ______________________________	
	|__|	**Relationship** (1=1st 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
	|__|	**Are you currently living in the same household with the participant?** (0=No, 1=Yes, 9=Unk)
	|__|	**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 ______________________________	
	|__|	**Relationship** (1=1st 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
	|__|	**Are you currently living in the same household with the participant?** (0=No, 1=Yes, 9=Unk)
	|__|	**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.)

TECH13

Mini-Mental State Exam

Sentence and Design Handout for Participant

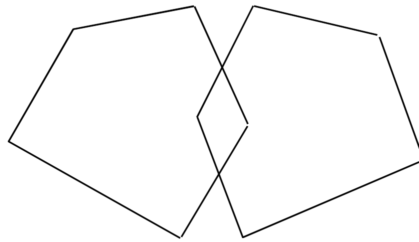
PLEASE WRITE A SENTENCE

____

____

____

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____

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

RESULT	**Reason for further evaluation:** *(Check ALL that apply)*.	
|__|	**Blood Pressure** **result** ______/_______ mmHg	SBP or DBP 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:_________________

____

REF1

COHORT EXAM 30

Date:___________

Medical History—Hospitalizations, ER Visits, MD Visits

Date of Last Exam: 01/01/2000
Date of Last Health History Update: No MHU

Health Care	
Since your last exam or health update	
|__|__|__|	**1st Examiner ID** ________________________ 1st Examiner Name
|__|	**Hospitalizations** (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.)
|__|__| |__|__| |__|__|__|__| MM DD YYYY	**Date of this FHS exam** *(Today's date - See above)*

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

MD01

Medical History (Continued)

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

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, 3=Maybe, 9=Unk.)

Aspirin Use

|__| **Take aspirin regularly**? (0=No, 1=Yes, 9=Unk.)

If yes, fill

|__|__| **Number aspirins taken regularly** (99=Unk.)

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

|__|__|__| **Usual aspirin dose for above** (Examples: 081=baby, 160=half dose, 250= like in Excedrin, 325=usual dose, 500=extra strength, 999=Unk.)

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. In

|__| **Medication bag with medications brought to exam or med's bottles/packs used by examiner to complete form?** (0=No 1=Yes) *****List medications taken regularly in past mo*** *Code ASPIRIN ONLY on screen MD02.*

Medication Name (Print first 20 letters)	**Strength** (include mg, IU, etc)	**Route** 1= Oral, 2=topical, 3=injection, 4=inhaled, 5=drops, 6=other	***Fill*** **Nur** (day/weel			
EXAMPLE: S A M P L E D R U G N A M E	100 mg		1			
| | | | | | | | | | | | | | | | | | |						
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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	***Fill***		
			Nun (day/week		
EXAMPLE: S A M P L E D R U G N A M E	100 mg		1		

MD04

Blood Pressure and Heart Problems

Blood Pressure First reading	
For clinic and offsite visits Examiner ID# equals Examiner ID# in Health Care section.	
Systolic	**Protocol modification**
|__|__|__| to nearest 2 mm Hg	|__| 0=No, 1=Yes, 9=Unk.
Diastolic	**Cuff size**
|__|__|__| to nearest 2 mm Hg	|__| 0=pediatric,1=regular adult, 2=large adult, 3= thigh, 9=Unk.

Note: If the participant/proxy answers yes to any of the following questions please record details of event on Screen MD01 & MD02

Heart Problems		
Since the date of the last Framingham Heart Study exam or health update, have you seen a doctor or other healthcare provider or been hospitalized for:		
|__|	**Chest pain, angina or angina pectoris**	
|__|	**Heart attack or myocardial infarction or MI**	
|__|	**Heart failure or congestive heart failure or CHF**	
|__|	**Heart catherization or cardiac catherization**	0=No,
|__|	**Heart bypass operation or coronary bypass surgery or CABG**	
|__|	**Procedure to unblock narrowed blood vessels to your heart muscles (PTCA, coronary angioplasty, or coronary stent)**	1=Yes,
|__|	**Atrial fibrillation or atrial flutter (A-fib or AF)**	9=Unk.
|__|	**Other heart problems (pacemaker, valve problem, aorta surgery, rhythm problem)** **Specify:____**	
|__|	**Exercise Tolerance Test, Stress Test**	

MD05

Note: If the participant/proxy answers yes to any of the following questions please record details of event on Screen MD01 & MD02

Circulatory Problems		
Since the date of the last Framingham Heart Study exam or health update, have you seen a doctor or other healthcare provider or been hospitalized for:		
|__|	**Stroke, TIA (transient ischemic attack, mini-stroke) Symptoms may include: sudden muscle weakness or numbness on one side, speech difficulty, and/or loss of vision in one or both eyes).**	
|__|	**Procedure to unblock narrowed blood vessels in your neck (carotid endarectomy, carotid angioplasty)**	
|__|	**Poor blood circulation or blocked or narrowed blood vessels to the legs or feet (claudication, peripheral artery disease, intermittent claudication)**	0=No,
|__|	**Thoracic or Abdominal aorta surgery**	1=Yes,
|__|	**Bypass procedure on the arteries in your legs (femoral or lower extremity bypass surgery, PTA, percutaneous angioplasty, stent)**	9=Unk.
|__|	**Amputation because of poor circulation**	
|__|	**Blood clot or embolism in leg or lung (Deep Vein Thrombosis – DVT or Pulmonary Embolus - PE)**	
|__|	**Other circulatory problem or cardiovascular procedure Specify:________________________________**	

Respiratory Problems		
Since the date of the last Framingham Heart Study exam or health history update, have you seen a doctor or other healthcare provider or been hospitalized for:		
|__|	**Chronic Bronchitis**	0=No, 1=Yes, 9=Unk.
|__|	**Emphysema**	
|__|	**COPD (Chronic Obstructive Pulmonary Disease)**	
|__|	**Sleep Apnea**	

MD06

Note: If the participant/proxy answers yes to any of the following questions please record details of event on Screen MD01 & MD02

Neurological Problems

Since the date of the last Framingham Heart Study exam or health history update, have you seen a doctor or other healthcare provider or been hospitalized for:

		0=No, 1=Yes, 9=Unk.
|__|	**Memory Problems, Dementia or Alzheimer's Disease**	
|__|	**Other neurological problems such as Parkinson's Disease, Multiple Sclerosis, seizures, head injury** **Specify:____**	
|__|	**Have you had an MRI scan of your head other than for the Framingham Heart Study?** **Name of MRI facility:________________________________** **Date of MRI: __ __ -__ __-__ __ __ __**	

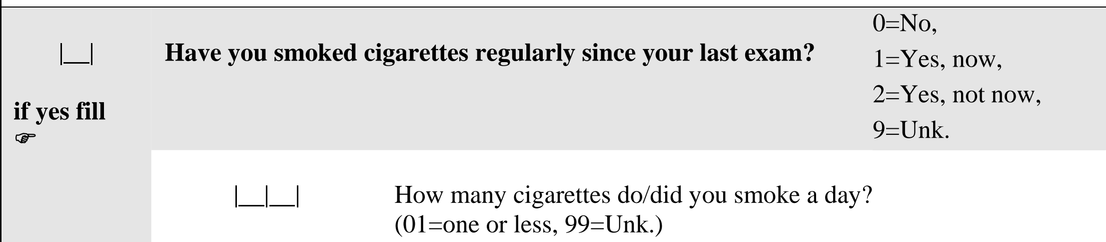
Other Problems

Since the date of the last Framingham Heart Study exam or health history update, have you seen a doctor or other healthcare provider or been hospitalized for:

		0=No, 1=Yes, 9=Unk.
|__|	**Diabetes**	
|__|	**Cancer** **Specify type:_____________________________________** **Physician:_______________________________________** **Place where biopsy performed:____________________** **____** **____**	
|__|	**Fracture, broken bone** **Specify location(s):________________________________**	

MD07

Smoking



|__|	**Have you smoked cigarettes regularly since your last exam?**	0=No, 1=Yes, now, 2=Yes, not now, 9=Unk.
if yes fill ☞	|__|__|	How many cigarettes do/did you smoke a day? (01=one or less, 99=Unk.)

Alcohol Consumption

|__|	**Check if over past year participant drinks less than one alcoholic drink of any type per month.**

Do you drink any of the following beverages at least once a month?
(0=no, 1=yes, 9=Unk.)

|__|	Beer
|__|	Wine
|__|	Liquor/spirits

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

Code alcohol intake as EITHER weekly OR monthly as appropriate.

Beverage	Per week	Per month
Beer (12oz bottle, glass, can)	|__|__|__|	|__|__|__|
Wine (red or white, 4oz glass)	|__|__|__|	|__|__|__|
Liquor/spirits (1oz cocktail/highball)	|__|__|__|	|__|__|__|

MD08

Blood Pressure Second reading	
For clinic and offsite visits Examiner ID# equals Examiner ID# in Health Care section.	
Systolic	**Protocol modification**
|__|__|__| to nearest 2 mm Hg	|__| 0=No, 1=Yes, 9=Unk.
Diastolic	**Cuff size**
|__|__|__| to nearest 2 mm Hg	|__| 0=pediatric,1=regular adult, 2=large adult, 3= thigh, 9=Unk.

Interviewer Comments/NH Chart Diagnosis:

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MD09

Electrocardiograph--Part I

|__|__|__|	**Examiner ID Number** ____________________ **Examiner Last Name**
|__| **if Yes, fill out rest of form**	**ECG done (0=No, 1=Yes)**
	Rates and Intervals
|__|__|__|	**Ventricular rate per minute** (999=Unk.)
|__|__|__|	**P-R Interval (hundredths of a second)** (999=Fully Paced, Atrial Fib, or Unk.)
|__|__|__|	**QRS interval (hundredths of second)** (999=Fully Paced, Unk.)
|__|__|__|	**Q-T interval (hundredths of second)** (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, 99=Unk.)

MD10

Electrocardiograph-Part II

	Myocardial Infarction Location	
|__|	**Anterior**	(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.)
|__|	**Inferior**	
|__|	**True Posterior**	
	Left Ventricular Hypertrophy Criteria	
|__|	**R > 20mm in any limb lead**	(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)
|__|	**R > 11mm in AVL**	
|__|	**R in lead I plus S ≥ 25mm in lead III**	
	Measured Voltage	
*|__|__|	**R AVL in mm** (at 1 mv = 10 mm standard) *Be sure to code these voltages*	
*|__|__|	**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	
|__|	**R≥ 25mm**	0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk
|__|	**S≥ 25mm**	
|__|	**R or S ≥ 30mm**	
|__|	**R + S ≥ 35mm**	
|__|	**Intrinsicoid deflection ≥ .05 sec**	
|__|	**S-T depression (strain pattern)**	
	Hypertrophy, enlargement, and other ECG Diagnoses	
|__|	**Nonspecific S-T segment abnormality** (0=No, 1=S-T depression, 2=S-T flattening, 3=Other, 9=Fully paced or Unk.)	
|__|	**Nonspecific T-wave abnormality** (0=No, 1=T inversion, 2=T flattening, 3=Other, 9=Fully paced or Unk.)	
|__|	**U-wave present** (0=No, 1=Yes, 2=Maybe, 9=Paced or Unk.)	
|__|	**Atrial enlargement** (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unk.)	
|__|	**RVH** (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.; If complete RBBB present, RVH=9)	
|__|	**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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Non-Cardiovascular Diagnoses Physician Opinions		
|__|	**Diabetes Mellitus**	0=No, 1=Yes, 2=Maybe, 9=Unk.
|__|	**Prostate disease**	
|__|	**Renal disease (specify)____________________**	
|__|	**Emphysema**	
|__|	**Chronic bronchitis**	
|__|	**Pneumonia**	
|__|	**Asthma**	
|__|	**Other pulmonary disease**	
|__|	**Gout**	
|__|	**Degenerative joint disease**	
|__|	**Rheumatoid arthritis**	
|__|	**Gallbladder disease**	
|__|	**Other non C-V diagnosis**	

Comments CDI Other Diagnoses

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MD12