

Exam 8 Procedures Sheet

<input type="checkbox"/>	Informed Consent Signed	0=No, 1=Yes, 2=Consent signed, may qualify for waiver 3=Waiver used, 4=Other
<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"/>	Exercise Questionnaire	
<input type="checkbox"/>	Mini-Mental Status Exam	0=No,
<input type="checkbox"/>	Urine Specimen	
<input type="checkbox"/>	Blood Draw	1=Yes,
<input type="checkbox"/>	ECG	
<input type="checkbox"/>	Observed performance (Timed walk hand grip)	
<input type="checkbox"/>	Tonometry /ECHO/Carotid	
<input type="checkbox"/>	Ankle-brachial blood pressure by Doppler.	8=Offsite visit
<input type="checkbox"/>	Spirometry	
<input type="checkbox"/>	Post bronchodilator Spirometry	
<input type="checkbox"/>	Diffusion Capacity	
<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, 8=Other, 10=equipment problems
<input type="checkbox"/>	Reason post bronchodilator test not done	
<input type="checkbox"/>	Reason Diffusion not done	

Exit Interview

	Examiner ID	
<input type="checkbox"/>	Procedure sheet reviewed	
<input type="checkbox"/>	Referral sheet reviewed	0=No
<input type="checkbox"/>	Willett dietary questionnaire provided (if not completed in clinic)	1=Yes
<input type="checkbox"/>	Left clinic w/ belongings	8=Offsite
<input type="checkbox"/>	Feedback	0=No feedback, 1=Positive feedback, 2=Negative feedback, 3=Other
	Comments _____	

TECH02

For Participants Wish to Complete Their Exam on a Second Visit

OMB NO=0925-0216 12/31/2007

____ - ____ - ____	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)
--------------------	---

Keys: 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.

Exam 8 Procedures Sheet		
<input type="checkbox"/>	MD Questionnaire.	
<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"/>	Exercise Questionnaire	0=No,
<input type="checkbox"/>	Mini-Mental Status Exam	
<input type="checkbox"/>	Urine Specimen	1=Yes,
<input type="checkbox"/>	Blood Draw	
<input type="checkbox"/>	ECG	
<input type="checkbox"/>	Observed performance (Timed walk hand grip)	
<input type="checkbox"/>	Tonometry /ECHO/Carotid	8=Offsite visit
<input type="checkbox"/>	Ankle-brachial blood pressure by Doppler.	
<input type="checkbox"/>	Spirometry	
<input type="checkbox"/>	Post bronchodilator Spirometry	
<input type="checkbox"/>	Diffusion Capacity	
<input type="checkbox"/>	Reason Spirometry not done	1=Major Surgery, 2=Heart Attack
<input type="checkbox"/>	Reason post bronchodilator test not done	3=Stroke, 4=Aneurysm, 5=BP>210/110
<input type="checkbox"/>	Reason Diffusion not done	6=Refused, 7=Test Aborted, 8=Other, 10=equipment problems

TECH02a

Rosow-Breslau Scale

OMB NO=0925-0216 12/31/2007

<input type="text"/> <input type="text"/> <input type="text"/>	Examiner's Number for Socio-demographics															
Socio-demographics																
<input type="text"/>	Where do you live? (0=Private residence, 1=Nursing home, 2=Other institution, such as: assisted living, retirement community, 9=Unknown)															
<input type="text"/>	Does anyone live with you? (0=No, 1=Yes, 9=Unknown) Code Nursing Home Residents as NO to these questions															
If Yes ☛ If 0 or 9, skip down	<table style="width:100%; border:none;"> <tr> <td style="width:10%; text-align:center; vertical-align: top;"><input type="text"/></td> <td style="padding: 2px;">Spouse</td> <td style="padding: 2px;">0=No</td> </tr> <tr> <td style="text-align:center; vertical-align: top;"><input type="text"/></td> <td style="padding: 2px;">Significant Other</td> <td style="padding: 2px;">1=Yes, less than 3 months per year</td> </tr> <tr> <td style="text-align:center; vertical-align: top;"><input type="text"/></td> <td style="padding: 2px;">Children</td> <td style="padding: 2px;">2=Yes, more than 3 months per year</td> </tr> <tr> <td style="text-align:center; vertical-align: top;"><input type="text"/></td> <td style="padding: 2px;">Friends</td> <td style="padding: 2px;">9=Unknown</td> </tr> <tr> <td style="text-align:center; vertical-align: top;"><input type="text"/></td> <td style="padding: 2px;">Relatives</td> <td></td> </tr> </table>	<input type="text"/>	Spouse	0=No	<input type="text"/>	Significant Other	1=Yes, less than 3 months per year	<input type="text"/>	Children	2=Yes, more than 3 months per year	<input type="text"/>	Friends	9=Unknown	<input type="text"/>	Relatives	
<input type="text"/>	Spouse	0=No														
<input type="text"/>	Significant Other	1=Yes, less than 3 months per year														
<input type="text"/>	Children	2=Yes, more than 3 months per year														
<input type="text"/>	Friends	9=Unknown														
<input type="text"/>	Relatives															

Use of Nursing and Community Services		
<input type="text"/>	Have you been admitted to a nursing home (or skilled facility) in the past year)	0=No 1=Yes
<input type="text"/>	In the past year, have you been visited by a nursing service, or used home, community, or outpatient programs?	9=Unknown

Rosow-Breslau Questions		
<input type="text"/>	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
<input type="text"/>	Are you able to walk half a mile without help? (About 4-6 blocks)	9=Unknown
<input type="text"/>	Are you able to walk up and down one flight of stairs without help?	

CES-D Scale (Self-administered)

The questions below ask about your feelings.

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)
1. I felt that everything I did was an effort.	0	1	2	3
2. I could not "get going"	0	1	2	3

TECH03

Katz Activities of Daily Living Scale

OMB NO=0925-0216 12/31/2007

_ _ _	Examiner's Number for Activities of Daily Living
<p>During the Course of a Normal Day, Can you do the following activities independently or do you need human assistance or the use of a device? Coding: 0=No help needed, independent, 1=Uses device, independent, 2=Human assistance needed, minimally dependent, 3=Dependent, 4=Do not do during a normal day, 9=Unknown</p>	
<input type="checkbox"/>	<p>Dressing (undressing and redressing) Devices such as: velcro, elastic laces;</p>
<input type="checkbox"/>	<p>Bathing (including getting in and out of tub or shower) Devices such as: bath chair, long handled sponge, hand held shower, safety bars;</p>
<input type="checkbox"/>	<p>Eating Devices such as: rocking knife, spork, long straw, plate guard.</p>
<input type="checkbox"/>	<p>Transferring(getting in and out of a chair) Devices such as: sliding board, grab bars, special seat;</p>
<input type="checkbox"/>	<p>Toileting Activities (using bathroom facilities and handle clothing) Devices such as: special toilet seat, commode;</p>

TECH04

Physical Activity Questionnaire--Framingham Heart Study

Tech-administered

OMB NO=0925-0216 12/31/2007

<input style="width: 40px; height: 15px; border: none;" type="text"/> <input style="width: 40px; height: 15px; border: none;" type="text"/> <input style="width: 40px; height: 15px; border: none;" type="text"/> <input style="width: 40px; height: 15px; border: none;" type="text"/> Examiner ID	
Rest and Activity for a Typical Day (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

<input style="width: 20px; height: 15px; border: none;" type="checkbox"/>	What is your normal walking pace outdoors?
	0 = Unable to walk 1 = Easy, casual, slow (less than 2 miles per hour) 2 = Normal, average (2 to 2.9 miles per hour) 3 = Brisk pace (3 to 3.9 miles per hour) 4 = Very brisk pace (4 to 4.9 miles per hour) 9 = Unknown
<input style="width: 20px; height: 15px; border: none;" type="checkbox"/>	How many flights of stairs (not steps) do you climb daily? (10 stairs per flight)
	0 = No flights 1 = 1-2 flights 2 = 3-4 flights 3 = 5-9 flights 4 = 10-14 flights 5 = >15 flights 9 = Unknown

TECH05

Physical Activity Questionnaire--Framingham Heart Study Tech-administered

OMB NO=0925-0216 12/31/2007

I am going to read a list of activities. Please tell me which activities you have done in the past year.

Examiner ID		In _ typical 2 week period of time, how often do you (name of activity)	Average time/session		Number months/year
During past year	0=No, 1=Yes, 8=Refused, 9=Unknown		hours	minutes	0-12
<input type="checkbox"/>	Walking for exercise	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Calisthenics/general exercise	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Moderate strenuous household chores	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Mowing the lawn	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Gardening	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Hiking	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Jogging	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Biking	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Exercise cycle, ski or stair machine	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Dancing	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Aerobics	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Golf	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Swimming	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Weight training (free weights, machines)	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Other, write in _____	_ _	_ _	_ _	_ _
<input type="checkbox"/>	Other, write in _____	_ _	_ _	_ _	_ _

TECH06

Nagi Questions

OMB NO=0925-0216 12/31/2007

<input type="text"/> <input type="text"/> <input type="text"/>	Examiner's Number for Activities - Part B
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 (6) Unable to Assess Difficulty Because not Done as Part of Daily Activities (9) Unknown	
<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)

TECH07

Falls/Fractures

OMB NO=0925-0216 12/31/2007

_ _ _	Examiner's Number for Activities - Part C
-------	--

Fractures			
_	<p>Since Your Last Clinic Visit Have You Broken Any Bones? (Code: 0=No, 1=Yes, 2=Unsure, 9=Unknown)</p>		
If Yes, fill	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; text-align: center;"> _ _ </td> <td style="text-align: center;">Location of fracture:</td> </tr> </table>	_ _	Location of fracture:
_ _	Location of fracture:		
	<p>Location (code unknown as 99)</p>		
	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) _____		

TECH08

Cognitive Function--Part I

OMB NO=0925-0216 12/31/2007

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

<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Examiner's Number for Cognitive Function -- Part I+II
SCORE CORRECT No Try=6 Unknown=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, 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
<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	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=Unknown
0 1 2 3 6 9	What are the 3 objects I asked you to remember a few moments ago?

TECH09

Cognitive Function --Part II

OMB NO=0925-0216 12/31/2007

SCORE CORRECT No Try=6 Unknown=9	Write all responses on exam form.
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)

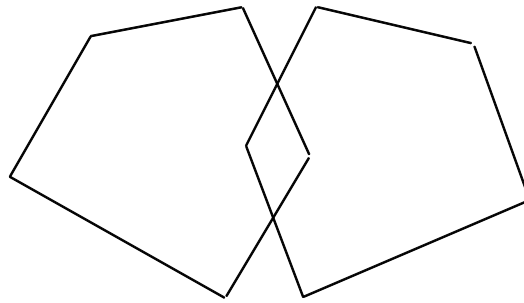
No Yes Maybe Unk (coding below)	Factor Potentially Affecting Mental Status Testing
0 1 2 9	Illiterate or low education
0 1 2 9	Not fluent in English
0 1 2 9	Poor eyesight
0 1 2 9	Poor hearing
0 1 2 9	Depression / possible depression
0 1 2 9	Other, write in _____

TECH10

Sentence and Design Handout for Participant

PLEASE WRITE A SENTENCE

PLEASE COPY THIS DESIGN



Observed performance. Part 1

OMB NO=0925-0216 12/31/2007

<input style="width: 30px; height: 20px;" type="text"/>	Examiner's Number
---	--------------------------

HAND GRIP TEST Measured to the nearest kilogram			
Right hand			
Trial 1	99=Unknown		_ _
Trial 2	99=Unknown		_ _
Trial 3	99=Unknown		_ _
Left hand			
Trial 1	99=Unknown		_ _
Trial 2	99=Unknown		_ _
Trial 3	99=Unknown		_ _
Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown)			_
If not attempted or completed, why not?			
1=Physical limitation	3=Other _____	write in	_
2=Refused	9=Unknown		

TECH11

Observed performance. Part 2

OMB NO=0925-0216 12/31/2007

<input style="width: 30px; height: 20px;" type="text"/>	Examiner's Number
---	--------------------------

MEASURED WALKS	
Walking aid used: 0=No aid, 1=Cane, 2=Walker, 3=Wheelchair, 4=Other, 9=Unknown	
First Walk	
Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown)	
If not attempted or completed, why not?	
1=Physical limitation	3=Other _____ write in
2=Refused	9=Unknown
Walk time (in seconds, 99.99=Unknown)	*
Second Walk	
Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown)	
If not attempted or completed, why not?	
1=Physical limitation	3=Other _____ write in
2=Refused	9=Unknown
Walk time (in seconds, 99.99=Unknown)	*
Quick Walk	
Was this test completed? (0=No, 1=Yes, 8=Not attempted, 9=Unknown)	
If not attempted or completed, why not?	
1=Physical limitation	3=Other _____ write in
2=Refused	9=Unknown
Walk time (in seconds, 99.99=Unknown)	*

TECH12

Doppler Ankle Brachial Blood Pressure Measurements. Tech- Obtained

OMB NO=0925-0216 12/31/2007

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

_ _ _	Examiner's Number for Doppler Ankle Brachial Blood Pressure.	
_ _	Cuff size, arm	0= pediatric, 1= regular adult 2= large adult, 3= thigh
_ _	Cuff size, ankle	

_ _ _	Right arm	300= \geq 300
_ _ _	Right ankle	
_ _ _	Left ankle	999= Unknown or not done
_ _ _	Left arm	

REPEAT SYSTOLIC BLOOD PRESSURE MEASUREMENTS (reverse order)

_ _ _	Left arm	300= \geq 300
_ _ _	Left ankle	
_ _ _	Right ankle	999= Unknown or not done
_ _ _	Right arm	

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

_ _ _	Left arm	300= \geq 300
_ _ _	Left ankle	
_ _ _	Right ankle	999= Unknown or not done
_ _ _	Right arm	

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

EXCLUSIONS:

Right	Left	
_ _	_ _	Lower Extremity Exclusions 0= None, 1= venous stasis ulceration, 2= amputation, 3= other _____
_ _	_ _	Upper Extremity Exclusions 0= None, 1=Mastectomy, 3= Other _____

_ _	Protocol modification, write in _____ _____	0= No, 1= Yes 2=Incomplete/ refused
-----	---	---

TECH13

Respiratory Disease Questionnaire. Technician Administered.

OMB NO=0925-0216 12/31/2007

Respiratory Diagnoses			
_ _ _	Examiner ID		
_	1. Since your last exam have you had asthma?		0=No
If yes, fill ☞	_	Do you still have it?	
	_	Was it diagnosed by a doctor or other health professional?	
	_ _	At what age did it start? (Age in years)	1=Yes
	_ _	If you no longer have it, at what age did it stop? (Age in years)	
	_	Have you received medical treatment for this in the past 12 months?	88=N/A
_	2. Since your last exam have you had hay fever (allergy involving the nose and/or eyes)?		0=No 1=Yes
_	3. Since your last exam have you had pneumonia (including bronchopneumonia)?		
4. Since your last exam have you had			
	Condition?	Health professional DX?	Age condition began
	(0=No, 1=Yes)		99=Unk
Chronic Bronchitis	_	_	_ _
Emphysema	_	_	_ _
COPD <small>Chronic obstructive pulmonary disease</small>	_	_	_ _
Sleep Apnea	_	_	_ _
Pulmonary Fibrosis	_	_	_ _

Inhaler Use			
_	5. Do you take inhalers or bronchodilators?		0=No
If yes, fill ☞	_	Do you use any of these medications- Albuterol, Proventil, Ventolin, Combivent, Maxair, Volmax, Xopenex, Bronkometer, pirbuterol, levalbuterol, or metaproterenol	1=Yes
	_ _	How many hours ago did you last use the medication, either by inhaler or nebulizer? (Time in hours)	0=No 1=Yes
	_	Do you take any of the following inhalers? Serevent, Advair, Foradil, salmeterol, or formoterol	
	_ _	How many hours ago did you last use the medication? (Time in hours)	0=No 1=Yes

TECH14

Respiratory Disease Questionnaire. Technician Administered.

OMB NO=0925-0216 12/31/2007

Triggered airway symptoms

1. 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

- | | | |
|--------------------------|--|---------------|
| <input type="checkbox"/> | Start to cough? | |
| <input type="checkbox"/> | Start to wheeze? | |
| <input type="checkbox"/> | Get a feeling of tightness in your chest? | 0=No
1=Yes |
| <input type="checkbox"/> | Start to feel short of breath? | |
| <input type="checkbox"/> | Get a runny or stuffy nose or start to sneeze? | |
| <input type="checkbox"/> | Get itching or watering eyes? | |

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

- | | | |
|--------------------------|--|---------------|
| <input type="checkbox"/> | Start to cough? | |
| <input type="checkbox"/> | Start to wheeze? | 0=No
1=Yes |
| <input type="checkbox"/> | Get a feeling of tightness in your chest? | |
| <input type="checkbox"/> | Start to feel short of breath? | |
| <input type="checkbox"/> | Get a runny or stuffy nose or start to sneeze? | |
| <input type="checkbox"/> | Get itching or watering eyes? | |

- | | | |
|--------------------------|--|---------------|
| <input type="checkbox"/> | 3. Do you currently have a cat, dog, or other furry pets living in your home? | 0=No
1=Yes |
|--------------------------|--|---------------|

TECH15

Proxy form

OMB NO=0925-0216 12/31/2007

<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	<input type="checkbox"/> 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=Unknown)
	<input type="checkbox"/> * <input type="checkbox"/> 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=Unknown)
	<input type="checkbox"/> 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=Unknown)
	<input type="checkbox"/> * <input type="checkbox"/> 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=Unknown)

TECH016

Sociodemographic questions. Part I Self-administered

OMB NO=0925-0216 12/31/2007

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

TECH17

Sociodemographic questions. Part II. Self-administered

OMB NO=0925-0216 12/31/2007

What is your current occupation? Write in _____

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

YES **NO** Do you have some form of health insurance?

YES **NO** Do you have prescription drug coverage?

TECH18

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

OMB NO=0925-0216 12/31/2007

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"/>

TECH19

SF-12 Health Survey (Standard) Self-administered

OMB NO=0925-0216 12/31/2007

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"/>

TECH20

Sleep Questionnaire. Part 1 Self-administered

OMB NO=0925-0216 12/31/2007

<input style="width: 20px; height: 20px;" type="text"/>	How much sleep do you usually get at night (or your main sleep period) on weekdays or work days? (Number of hours)
hours	
<input style="width: 20px; height: 20px;" type="text"/>	How long does it usually take you to fall asleep at bedtime? (Number of hours, 1=1 hour or less)
hours	

Sleep Related Symptoms (days/nights)	
<input style="width: 20px; height: 20px;" type="text"/>	In the past 12 months, how often do you snore while you are sleeping?
<input style="width: 20px; height: 20px;" type="text"/>	In the past 12 months, how often do you snort, gasp, or stop breathing while you are asleep?

0=Never
 1=Rarely(1-2 nights/week)
 2=Occasionally(3-4 nights/week)
 3=Frequently(5/more nights/week)
 9=Don't know

Please indicate how often <u>in the past month</u> you experienced each of the following. (Circle one response for each item)					
	Never	Rarely (1/month or less)	Sometimes (2-4/month)	Often (5-15/month)	Almost always (16-30/month)
Have trouble falling asleep	0	1	2	3	4
Wake up during the night and have trouble getting back to sleep.	0	1	2	3	4
Wake up too early in the morning and be unable to get back to sleep.	0	1	2	3	4
Feel excessively (or overly) sleepy during the day.	0	1	2	3	4

TECH21

Sleep Questionnaire. Part 2

Self-administered

OMB NO=0925-0216 12/31/2007

What is the chance that you would doze off or fall asleep (not just “feel tired”) in each of the following situations? (Circle one response for each situation. If you are never or rarely in the situation, please give your best guess for that situation)

	No	Slight	Moderate	High
Sitting and reading	0	1	2	3
Watching TV.	0	1	2	3
Sitting inactive in a public place (such as theater or a meeting)	0	1	2	3
Riding as a passenger in a car for an hour without a break.	0	1	2	3
Lying down to rest in the afternoon when circumstances permit.	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol.	0	1	2	3
In a car, while stopped in traffic for a few minutes.	0	1	2	3
At the dinner table.	0	1	2	3
While driving	0	1	2	3

Have you ever been told by a doctor or other health professional that you have any of the following?
(Circle one response for each item)

	No	Yes	Don't know
Sleep apnea or obstructive sleep apnea.	0	1	9
Insomnia.	0	1	9
Restless legs.	0	1	9

TECH22

Vascular Testing

OMB NO=0925-0216 12/31/2007

Exam 8			
Framingham Study Vascular Function Participant Worksheet			
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Keyer 1: _____</td> <td style="width: 50%;">Keyer 2: _____</td> </tr> </table>	Keyer 1: _____	Keyer 2: _____
Keyer 1: _____	Keyer 2: _____		
0 1 9 If yes, discontinue PAT	Do you have a latex allergy? (0=No, 1=Yes, 9=Unknown)		
0 1 9 If yes, discontinue brachial	Do you have active Raynaud's disease, as manifested by daily attacks of Raynaud's currently blue fingers or ischemic finger ulcers? (0=No, 1=Yes, 9=Unknown)		
0 1 2 3 8 9 If 1(right), discontinue brachial If 2(left), BP on right	Women Only: Have you had a radical mastectomy on right side? A radical mastectomy is the removal of the breast, associated lymph nodes, and underlying musculature. Does NOT include lumpectomy or simple mastectomy. (0=No, 1=Yes, right, 2=Yes, left, 3=Yes, both, 8=Male, 9=Unknown)		
0 1 9 if yes fill	Have you had any caffeinated drinks in the last 6 hours? (0=No, 1=Yes, 9=Unknown) [][] How many cups? (99=Unkown)		
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 if yes fill	Have you smoked cigarettes in the last 6 hours? (0=No, 1=Yes, 9=Unkn) [][]:[][] If yes, how many hours and minutes since your last cigarette? (99:99=Unknown)		
PAT SCAN			
[][]/[][]/[][]	Date of PAT scan? (mo/day/yr)		
[][][]	PAT Sonographer ID		
[][]·[]	Room temperature (Celsius)		
[][][]	Mean systolic baseline blood pressure		
[][][]	Cuff inflation pressure (Baseline SBP + 50 or 250)		
0 1 2 If no (0) or partial (2) 	Was PAT protocol completed? (Determined at time of scan or at time of interpreting) 0=No: protocol was not completed i.e. none of 3 parts completed of Baseline, Doppler, Deflation. 1=Yes: protocol was done and completed i.e. all 3 parts completed of Baseline, Doppler, Deflation 2=Yes, Partial: protocol was partially completed i.e. 1 part of 3 completed, 2 of 3 completed of Baseline, Doppler, Deflation PAT scan deviations: circle ALL that apply 1: Subject refusal 2: Subject discomfort 3: Time constraint 4 Equipment problem (if not #5 or #6), specify _____ 5: Foot pedal problem/cuff sequence problem 6: Doppler problem 7: Other, specify _____		

TONOMETRY

OMB NO=0925-0216 12/31/2007

Tonometry	
_ _ / _ _ / _ _	Date of tonometry scan? Mo/Day/Yr
_ _ _	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.

Not for Data Entry.

Distances:

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

FHS ECHOCARDIOGRAPHY ULTRASONOGRAPHER WORKSHEET

Study Date ___/___/___ Study type **0 1 2** (0=exam, 1=repeat study, 2=other) EXAM ___

Data entry date ___/___/___ ; ___/___/___ Data entry ID _____ 1st _____ 2nd

ECHO done? ~ Yes=1 ~ No=0 Room # **106 108**
 Tech ID _____ Height (inches) _____ Sex **M F**

Video MOD # _____ if no video MOD, code 0 SVHS # _____ if no SVHS#, code 0 SVHS location _____

Images available for measuring: ~ Video images ONLY ~ Digital images ONLY
 (If neither box is checked, then both video and digital images were available for measuring)

STUDY QUALITY

<u>Quantitative</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>Inadequate</u>
M-mode Ao/LA	~ =1	~ =2	~ =3	~ =4
M-mode LV	~ =1	~ =2	~ =3	~ =4
2-D LV	~ =1	~ =2	~ =3	~ =4
PW mitral inflow	~ =1	~ =2	~ =3	~ =4
<u>Qualitative</u>				
2-D study	~ =1	~ =2	~ =3	~ =4
CW AV	~ =1	~ =2	~ =3	~ =4
Color Doppler	~ =1	~ =2	~ =3	~ =4
<u>Overall study quality</u>	~ =1	~ =2	~ =3	~ =4

Comments: _____

- ~ Priority MD overread:
- ~ Severe AS _____ regurgitation
- ~ Severe MS
- ~ Mod-severe
- ~ Thrombus
- ~ Vegetation
- ~ Mass
- ~ Large pericardial effusion
- ~ Significant LV dysfunction ≤ 30 % LVEF
- will call MD if Pt. not known to have cardiomyopathy or prior MI
- ~ Other _____
- ~ Ventricular wall thickness ≥ 15 mm
- Called Dr. _____
- Date/time: _____
- ~ MD overread, other:
- ~ > Mild LAE
- ~ > Mild AoR dil.
- ~ RA/RV abnormality
- ~ Any LVH
- ~ Any LVE
- ~ LV WMA 9 LVEF
- ~ MS
- ~ > Mild MAC
- ~ Any MVP
- ~ AS
- ~ Bicuspid AV
- ~ Valve prosthesis
- ~ > Mild _____ regurgitation
- ~ Other _____

Requested by: _____ For: _____
 Dr. _____ Date: _____
 Reader _____ OverReader _____ Reading **1 2** Date interpreted ___/___/___
 (mo/day/yr)

LA enlargement	~ 0=no	~ 1=borderln.	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
<i>Other LA comment</i>						
Mitral Valve	~ 0=normal	~ 1=prob nl	~ 2=abnormal		~ 4=prosth.	~ 9=unknown
MV thickening	~ 0=no	~ 1=minimal	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
MS	~ 0=normal	~ 1=possible	~ 2=likely			~ 9=unknown
MAC	~ 0=no	~ 1=minimal	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
MVP	~ 0=no	~ 1=min.sup.disp	~ 2=mild	3=moderate	~ 4=severe	~ 9=unknown
<i>Other MV comment</i>						
Aortic Valve	~ 0=normal	~ 1=prob nl	~ 2=abnormal		~ 4=prosth.	~ 9=unknown
AV thickening	~ 0=no	~ 1=minimal	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
AV cusp excursion	~ 0=normal	~ 1=minimal	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
Bicuspid AoV	~ 0=no	~ 1=yes	~ 2=maybe			~ 9=unknown
Aortic Root	~ 0=normal	~ 1=prob nl	~ 2=abnormal			~ 9=unknown
Aortic root dilation	~ 0=no		~ 2=present			~ 9=unknown
Aortic root calcium	~ 0=no	~ 1=minimal	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
<i>Other AV/AR comment</i>						
LV Structure	~ 0=normal	~ 1=prob nl	~ 2=abnormal			~ 9=unknown
LV enlargement	~ 0=no	~ 1=borderline	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
LVWT, concentric	~ 0=no	~ 1=borderline	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
LVWT, other	~ 0=no	~ 1=DUSK	~ 2=ASH	~ 3=ISH	~ 4=oth	~ 9=unknown
LV Regional WMA	~ 0=normal	~ 1=prob nl	~ 2=abnormal			~ 9=unknown
Septum	~ 0=normal	~ 1=paradoxical	~ 2=hypokinetic	~ 3=akinetic	~ 4=dyskinetic	~ 9=unknown
Anterior	~ 0=normal		~ 2=hypokinetic	~ 3=akinetic	~ 4=dyskinetic	~ 9=unknown
Anterior/Anterolateral	~ 0=normal		~ 2=hypokinetic	~ 3=akinetic	~ 4=dyskinetic	~ 9=unknown
Posterior	~ 0=normal		~ 2=hypokinetic	~ 3=akinetic	~ 4=dyskinetic	~ 9=unknown
Inferior	~ 0=normal		~ 2=hypokinetic	~ 3=akinetic	~ 4=dyskinetic	~ 9=unknown
Apex	~ 0=normal		~ 2=hypokinetic	~ 3=akinetic	~ 4=dyskinetic	~ 9=unknown
LV Systolic Function	~ 0=normal	~ 1=prob nl	~ 2=regional		~ 4=global	~ 9=unknown
LV ejection fraction	~ 0=normal	~ 1=borderline	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
<i>Other LV comment</i>						LVEF __ __%
Right Heart/Pericardium	~ 0=normal	~ 1=prob nl	~ 2=abnormal			~ 9=unknown
RA enlargement	~ 0=no	~ 1=borderline	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
RV enlargement	~ 0=no	~ 1=borderline	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
RV hypertrophy	~ 0=no/syst.		~ 2=small	~ 3=medium	~ 4=large	~ 9=unknown
Pericardial fluid						
<i>Other right !/pericardium</i>						
Valve Regurgitation	~ 0=none		~ 2=present			~ 9=unknown
Mitral	~ 0=none	~ 1=trace	~ 2=mild	~ 3=moderate	~ 4=m-s ~5=sev	~ 9=unknown
Aortic	~ 0=none	~ 1=trace	~ 2=mild	~ 3=moderate	~ 4=m-s ~5=sev	~ 9=unknown
Tricuspid	~ 0=none	~ 1=trace	~ 2=mild	~ 3=moderate	~ 4=m-s ~5=sev	~ 9=unknown
Mitral Stenosis	~ 0=none	~ 1=trivial	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
Aortic Stenosis	~ 0=none	~ 1=trivial	~ 2=mild	~ 3=moderate	~ 4=severe	~ 9=unknown
<i>Other Doppler comment</i>						

Comments: _____

Clinical correlation is suggested ~ 0=not applicable ~ 1=yes
Technically limited study ~ 0=no ~ 1=yes

**OFFSPRING EXAM 8 LOG BOOK SHEET FOR
TONOMETRY, PAT AND ECHO TESTS**

OMB NO=0925-0216 12/31/2007

Date of Clinic Visit ___ - ___ - ___
Mo Day Yr

Room # 106 108

TONOMETRY			
Test done?	yes <small>(test was done, even if all 4 pulses could not be acquired and recorded)</small>	no <small>(test was not attempted or done)</small>	If no, why: Circle all that apply
30 49 88 740 750 54 _ _ _ - _ _ _	Sonographer ID#		1. Subject refusal 2. Subject discomfort 3. Time constraint 4. Equipment problem, specify _____ 7. Other, specify _____
_ _ _ - _ _ _	Video CD#		
___/___/___	TONOMETRY test date if different from Clinic Date above.		

ECHO				
Test done?	yes <small>(test was done, even if recorded on video only)</small>	yes, partial <small>(i.e. only apical OR only parasternal images were acquired)</small>	no <small>(test was not attempted or done)</small>	If no or partial, why: Circle all that apply
30 49 88 740 750 _ _ _ - _ _ _	Sonographer ID#		1. Subject refusal 2. Subject discomfort 3. Time constraint 4. Equipment problem, specify _____ 7. Other, specify _____	
_ _ _ - _ _ _	SVHS#			
___/___/___	ECHO test date if different from Clinic Date above.			
MD overread required: <input type="checkbox"/> yes <input type="checkbox"/> no				

PAT				
Test done?	yes <small>(test was done) attempted</small>	yes, partial <small>(yes, partial test was done but suspect data problems)</small>	no <small>(test was not or done)</small>	If no or partial, why: Circle all that apply
30 49 88 740 750 54 _ _ _ - _ _ _	Sonographer ID#		1. Subject refusal 2. Subject discomfort 3. Time constraint 4. Equipment problem, specify _____ 5. test contraindication 7. Other, specify _____ 8. Latex allergy	
_ _ _ - _ _ _	Video CD#			
___/___/___	PAT test date if different from Clinic Date above.			

Date of exam

____/____/____

**Framingham Heart Study
Offspring Exam 8**

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); Echocardiogram findings will be forwarded at a later date **only if abnormal.**

Summary of Findings _____

1.No hx 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

OMB NO=0925-0216 12/31/2007

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

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Technician ID#
<input type="checkbox"/>	Was there an adverse event in clinic/offsite that does not require further medical evaluation? (0=No, 1=Yes, 9=Unkown) Comments: _____ _____
offsite inly if yes fill	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Technician ID# (OFFSITE visits only) <input type="checkbox"/> Was a FHS physician contacted during the examination due to adverse exam finding? (0=No, 1=Yes, 9=Unknown) Comments: _____ _____

TECH23

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

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

Date referral made: ___/___/___

Use 4 digits for year

ID number of person completing the referral: _____

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

TECH24

Medical History—Hospitalizations, ER Visits, MD Visits
Offspring EXAM 8

DATE _____

OMB NO=0925-0216 12/31/2007

Last exam on: «LExam»

Last Health History Update on: «LUpdate»

Health Care	
0	1st Examiner Prefix (0=MD, 1=Tech. for OFFSITE visit)
_ _ _	1st Examiner ID _____ 1st Examiner Name
_	Hospitalization (not just E.R.) since your last exam (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unknown)
_	E.R. Visit since your last exam (0=No; 1=Yes, 1 or more E. Room visit, 9=Unk)
_	Day Surgery (0=No, 1=Yes, 9=Unknown)
_	Major illness with visit to doctor (0=No, 1=Yes, 1 visit; 2=Yes, more than 1 visit; 9=Unk)
_	Have you had a fever or infection in past two weeks? (0=No, 1=Yes, 9=Unknown)
_	Check up by doctor in past 5 years (0=No, 1=Yes, 9=Unknown)
_____ MM DD YYYY	Date of this FHS exam (Today's date - See above)

Note: if FHS needs outside hospital record, please obtain details: mo/yr, hospital site.

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

Medical History—Medications

OMB NO=0925-0216 12/31/2007

<input type="checkbox"/> If yes, fill	Take aspirin regularly? (0=No, 1=Yes, 9=Unk)	
	<input type="text"/>	Number aspirins taken regularly (99=Unknown)
	<input type="text"/>	Frequency per (1=Day, 2=Week 3=Month, 4=Year, 9=Unk)
	<input type="text"/>	Usual dose (081=baby,160=half dose, 325=nl, 500=extra or larger,999=unk)




<input type="checkbox"/>	Since your last exam have you taken medication for hypertension/high blood pressure? (0=no, 1=yes,now, 2=yes,not now, 9=unk)
<input type="checkbox"/>	Since your last exam have you taken medication for high blood cholesterol or high triglycerides? (0=no, 1=yes, now, 2=yes,not now, 9=unk)
<input type="checkbox"/>	Since your last exam have you been told by a doctor you have high blood sugar or diabetes? (0=no, 1=yes,now, 2=yes,not now, 9=unk)
<input type="checkbox"/>	Since your last exam have you taken medication for cardiovascular disease (for example angina/chest pain,heart failure, atrial fibrillation/heart rhythm abnormality, stroke, leg pain when walking?) (0=no, 1=yes,now, 2=yes,not now, 9=unk)

MD02

Medical History–Female Reproductive History. Part 1.

| OMB NO=0925-0216 12/31/2007

If participant is male, leave questions blank

<input type="checkbox"/>	1. Since your last exam have you taken or used oral contraceptive 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=unknown)
If yes,	
fill 	What is the name of the current or most recent oral contraceptive, shot or implant used?
	_____ Name
	_____ Strength
	<input type="checkbox"/> Form (1=pill, 2=shot, 3=patch, 4=implant)
	_____/_____, ____/____ Duration of use (mo/yr began, mo/yr ended, year – 4 digits) 99/9999=Unknown, 88/8888=current user
<input type="checkbox"/>	2. Have you had a hysterectomy (uterus/womb removed) since your last exam? (0=no, 1=yes, 9=unknown)
If yes,	
fill 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Age at hysterectomy?
	____/____ Date of surgery (mo/yr) Use 4 digits for year 99/9999=Unknown
<input type="checkbox"/>	3. Since your last exam have you had an operation to remove one or both of your ovaries? (0=no, 1=yes, one ovary removed, 2=yes, two ovaries removed, 3=yes, unknown number of ovaries removed, 4=yes, part of an ovary removed, 9=unknown)
If yes,	
fill 	<input type="checkbox"/> <input type="checkbox"/> Age when ovaries removed? If more than one surgery, use age at last surgery

MD05

Medical History—Female Reproductive History. Part 2.

OMB NO=0925-0216 12/31/2007

<input type="checkbox"/>	4. Have your periods stopped (for one year or more)? (Have you reached menopause?) (0=not stopped, pregnant, breast feeding, 1=stopped but now have periods induced by hormones, 2=yes stopped>1 year, 3=yes stopped<1 year, 9=unknown)
--------------------------	---

Please fill in only one of the boxes below, not both!

IF PERIODS NOT STOPPED (pre-menopausal, pregnant, breast feeding!)	
___/___/___	When was the first day of your last menstrual period? (Use 4 digits for year, 99/9999=Unknown)
_ _	How many periods have you had in past 12 months?

IF PERIODS STOPPED (post-menopausal, post-menopausal on hormone replacement, or peri-menopausal on horm.repl.)	
---	--

<input type="checkbox"/>	a) Age when periods stopped (00=not stopped, 99=unknown) ! If periods now induced by hormones, code age when periods naturally stopped.												
<input type="checkbox"/>	b) Was your menopause natural or the result of surgery, chemotherapy, or radiation? (1=natural, 2=surgical, 3=chemo/radiation, 4=other, 9=unknown)												
<input type="checkbox"/>	c) Since your last exam have you taken hormone replacement therapy? (estrogen/progesterone) (0=no, 1=yes, now, 2=yes, not now, 9=unknown)												
If yes, fill	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;"> _ _ </td> <td style="padding: 5px;">What age did you begin hormone replacement therapy?</td> <td style="padding: 5px; text-align: right;">99=unknown</td> </tr> <tr> <td style="padding: 5px;"> _ _ years</td> <td style="padding: 5px;">For how long did you take hormones?</td> <td style="padding: 5px; text-align: right;">99/99=unknown</td> </tr> <tr> <td style="padding: 5px;"> _ _ months</td> <td></td> <td></td> </tr> </table>	_ _	What age did you begin hormone replacement therapy?	99=unknown	_ _ years	For how long did you take hormones?	99/99=unknown	_ _ months					
_ _	What age did you begin hormone replacement therapy?	99=unknown											
_ _ years	For how long did you take hormones?	99/99=unknown											
_ _ months													
<input type="checkbox"/> If yes, fill	<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="padding: 5px;">Estrogen use? (0=no, 1=yes, now, 2=yes, not now, 9=unknown)</td> </tr> <tr> <td style="width: 40%; padding: 5px;">_____</td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Name of most recent estrogen preparation</td> </tr> <tr> <td style="padding: 5px;"> _ _ . _ _ _ </td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Strength</td> </tr> <tr> <td style="padding: 5px;"> _ _ </td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Number of days per month taken</td> </tr> </table>	Estrogen use? (0=no, 1=yes, now, 2=yes, not now, 9=unknown)			_____		Name of most recent estrogen preparation	_ _ . _ _ _		Strength	_ _		Number of days per month taken
Estrogen use? (0=no, 1=yes, now, 2=yes, not now, 9=unknown)													
_____		Name of most recent estrogen preparation											
_ _ . _ _ _		Strength											
_ _		Number of days per month taken											
<input type="checkbox"/> If yes, fill	<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="padding: 5px;">Progesterone use? (0=no, 1=yes, now, 2=yes, not now, 9=unknown)</td> </tr> <tr> <td style="width: 40%; padding: 5px;">_____</td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Name of most recent progesterone preparation</td> </tr> <tr> <td style="padding: 5px;"> _ _ . _ _ </td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Strength</td> </tr> <tr> <td style="padding: 5px;"> _ _ </td> <td style="padding: 5px;"></td> <td style="padding: 5px;">Number of days per month taken</td> </tr> </table>	Progesterone use? (0=no, 1=yes, now, 2=yes, not now, 9=unknown)			_____		Name of most recent progesterone preparation	_ _ . _ _		Strength	_ _		Number of days per month taken
Progesterone use? (0=no, 1=yes, now, 2=yes, not now, 9=unknown)													
_____		Name of most recent progesterone preparation											
_ _ . _ _		Strength											
_ _		Number of days per month taken											
<input type="checkbox"/> If yes, fill	d) Have you used Evista (raloxifene) or Nolvadex (tamoxifen) or other selective estrogen receptor Modulator (SERM)? (0=no, 1=yes, now, 2=yes, not now, 9=unknown)												
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 5px;"> _ _ _ </td> <td style="padding: 5px;">Number of months used?</td> </tr> <tr> <td style="padding: 5px;"> _ </td> <td style="padding: 5px;">Current use? (0=no, 1=yes, raloxifene, 2=yes, tamoxifen, 3=yes, other, 9=unknown)</td> </tr> </table>	_ _ _	Number of months used?	_	Current use? (0=no, 1=yes, raloxifene, 2=yes, tamoxifen, 3=yes, other, 9=unknown)								
_ _ _	Number of months used?												
_	Current use? (0=no, 1=yes, raloxifene, 2=yes, tamoxifen, 3=yes, other, 9=unknown)												

Medical History--Smoking

OMB NO=0925-0216 12/31/2007

Cigarettes**Since your last exam have you smoked cigarettes regularly?** (No means less than 1 cigarette a day for 1 year.) (0=no, 1=yes, 9=unk)**If yes,
fill**

Have you smoked cigarettes regularly in the last year?

Do you now smoke cigarettes (as of 1 month ago)?

How many cigarettes do you smoke per day now?

On average, since your last exam, how many cigarettes did you smoke per day?

How old were you when you first started regular cigarette smoking? (99=Unk.)

If you have stopped smoking cigarettes completely, how old were you when you stopped?
(Age stopped, 00=not stopped, 99=Unk)

During the time you were smoking since your last exam, did you ever stop smoking for >6 months?

**If yes,
fill** During the time since your last exam, for how many years in total did you stop smoking cigarettes (00=never stopped)**Other****Since your last exam, have you regularly smoked a pipe or cigar?**0=No
1=Yes
9=Unknown**If yes,
fill**

Do you smoke a pipe or cigar now

MD07

Medical History –Alcohol Consumption.

OMB NO=0925-0216 12/31/2007


In the interim did you drink any of the following beverages at least once a month?				
Drink? 0=No, 1=Yes, 9=Ukn	Beverage	If yes, complete for number of drinks in a typical week/month over past year. <i>Code EITHER per week OR per month as appropriate.</i>	Number of drinks	
			Per week	OR Per month
			999=Unk	
<input type="checkbox"/>	Beer	12oz bottle, glass, can	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	Wine	4oz glass	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	Liquor/spirits	1 _ oz jigger	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	At what age did you stop drinking alcohol? (00= not stopped, 888=never drink99=Unknown)
<input type="checkbox"/>	Over the past year, on average on how many days per week did you drink an alcoholic beverage of any type? (1=1 or less, 9=Unknown)
<input type="checkbox"/> <input type="checkbox"/>	Over the past year, on a typical day when you drink, how many drinks do you have? (99=Unknown)
<input type="checkbox"/> <input type="checkbox"/>	What was the maximum number of drinks you had in 24 hr. period during the past month? (99=Unknown)
<input type="checkbox"/>	Has there ever been a time in your life when you drank 5 or more alcoholic drinks of any kind almost daily? (0=no, 1=yes, 9=unknown)

MD08

Medical History—Respiratory Symptoms. Part I

OMB NO=0925-0216 12/31/2007

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

MD09

Medical History—Respiratory Symptoms. Part II

OMB NO=0925-0216 12/31/2007

Nocturnal chest symptoms	
<input type="checkbox"/>	In the last 12 months, have you been awakened by shortness of breath?
<input type="checkbox"/>	In the last 12 months, have you been awakened by a wheezing/whistling in your chest?
<input type="checkbox"/>	In the last 12 months, have you been awakened by coughing?
if yes, fill all	<input type="checkbox"/> In the last 12 months, how often have you been awakened by coughing?
0=No 1=Yes 9=Don't know	
0=Not at all 9=Unknown 1=Most days or nights 2=A few days or nights a week 3=A few days or nights a month 4=A few days or nights a year	
Shortness of breath	
<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 ever have to stop for breath when walking at your own pace on level ground?
<input type="checkbox"/>	Do you ever have to stop for breath after walking 100 yards (or after a few minutes) on level ground?
0=No 1=Yes 9=Don't know	
<input type="checkbox"/>	Do you/have you needed to sleep on two or more pillows to help you breath? (Orthopnea)
<input type="checkbox"/>	Since your last exam have you had swelling in both your ankles (ankle edema)?
<input type="checkbox"/>	Since your last exam have you been told you had heart failure or congestive heart failure?
<input type="checkbox"/>	Since your last exam have you been hospitalized for heart failure?
Examiner's opinion:	
<input type="checkbox"/>	First examiner believes CHF
0=No, 1=Yes 2=Maybe, 9=Unkn	

Comments _____

MD10

Physician Blood Pressure (first reading)			
Systolic	Diastolic	BP cuff size	Protocol modification
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg	<input type="text"/> <input type="text"/> 0=pedi, 1=reg. adult, 2=large adult, 3= thigh, 9=unknown	<input type="text"/> <input type="text"/> 0=No, 1=Yes, 9=Unknown
Comments on protocol modification _____ _____			

MD11

Medical History—Chest pain

OMB NO=0925-0216 12/31/2007

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

<input type="checkbox"/>	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=Unknown
--------------------------	---	-----------------------------------

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

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

Comments _____

Medical History—Atrial Fibrillation/Syncope

OMB NO=0925-0216 12/31/2007

<input type="checkbox"/>	Have you been told you have/had a heart rhythm problem called atrial fibrillation? (0=No, 1=Yes, 2=Maybe,, 9=Unknown)																				
if yes, fill	<table border="0"> <tr> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;">* </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;">* </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> </tr> <tr> <td style="text-align: center;">mm</td> <td style="text-align: center;">dd</td> <td style="text-align: center;">yyyy</td> <td colspan="7"></td> </tr> </table> <p>Date of first episode (99/99/9999=unk) code year as 4 digits, example: Year 1999=1999</p> <p style="text-align: center;"><input type="checkbox"/></p> <p>ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn) Hospitalized at: _____ M.D. seen: _____</p>		*		*							mm	dd	yyyy							
	*		*																		
mm	dd	yyyy																			

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

<input type="checkbox"/>	History (since your last exam) of having a head injury with loss of consciousness (0=No, 1=Yes, 2=Maybe, 9=Unknown)																				
if yes, fill	<table border="0"> <tr> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;">* </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;">* </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> </tr> <tr> <td style="text-align: center;">mm</td> <td style="text-align: center;">dd</td> <td style="text-align: center;">yyyy</td> <td colspan="7"></td> </tr> </table> <p>Date of serious head injury with loss of consciousness (00/00/0000 =none, 99/99/9999=unk, Use 4 digits for year)</p>		*		*							mm	dd	yyyy							
	*		*																		
mm	dd	yyyy																			

<input type="checkbox"/>	History of a seizure disorder.. Since your last exam have you had a seizure? (0=No, 1=Yes, 2=Maybe,, 9=Unknown)																				
if yes, fill	<table border="0"> <tr> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;">* </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;">* </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> <td style="width: 10%; text-align: center;"> </td> </tr> <tr> <td style="text-align: center;">mm</td> <td style="text-align: center;">dd</td> <td style="text-align: center;">yyyy</td> <td colspan="7"></td> </tr> </table> <p>Date of most recent seizure (99/99/9999=unk) code four digit year</p> <p style="text-align: center;"><input type="checkbox"/></p> <p>Are you being treated for a seizure disorder? (0=No, 1=Yes, 2=Maybe, 9=Unknown)</p>		*		*							mm	dd	yyyy							
	*		*																		
mm	dd	yyyy																			

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

Comments: _____

Medical History—Cerebrovascular, Neurological and Venous Diseases

OMB NO=0925-0216 12/31/2007

Cerebrovascular Episodes Since Your Last Exam

<input type="checkbox"/>	Sudden muscular weakness	
<input type="checkbox"/>	Sudden speech difficulty	
<input type="checkbox"/>	Sudden visual defect	Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
<input type="checkbox"/>	Sudden double vision	
<input type="checkbox"/>	Sudden loss of vision in one eye	
<input type="checkbox"/>	Sudden numbness, tingling	
<input type="checkbox"/>	<input type="checkbox"/> Numbness and tingling is positional	
<input type="checkbox"/>	Head CT or MRI scan date ___-___-____ place _____	0=No,1=Yes, 2=both,9=Unkn.
<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)?	Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
<input type="checkbox"/>	Have you been told by a doctor you have Parkinson Disease?	
<input type="checkbox"/>	Have you been told by a doctor you have memory problems, dementia or Alzheimer's disease?	
<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 Opinions

<input type="checkbox"/>	TIA or stroke took place	0=No, 1=Yes, 2=Maybe, 9=Unkn
if yes or maybe fill ☛	<input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date (mo/yr, Use 4 digits for year, 99/9999=Unkn)
	Observed by _____	
	<input type="checkbox"/> <input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> * <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Duration (use format days/hours/mins, 99/99/99=Unknown)
<input type="checkbox"/>	Hospitalized or saw M.D. (0=No, 1=Hosp.2=Saw M.D, 9=Unk)	
	Name _____	
	Address _____	

Neurology
Comments _____**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, 2=Maybe, 9=Unknown
<input type="checkbox"/>	Since your last exam have you had a Pulmonary Embolus (blood clot in lungs)	

MD14

Medical History-- CVD Procedures

OMB NO=0925-0216 12/31/2007

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

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

Comments: _____

Physician Blood Pressure (second reading)			
Systolic	Diastolic	BP cuff size	Protocol modification
<input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unknown	<input type="text"/> <input type="text"/> <input type="text"/> to nearest 2 mm Hg 999=Unknwon	<input type="text"/> 0=pedi, 1=reg. adult, 2=large adult, 3= thigh, 9=Unknown	<input type="text"/> 0=No, 1=Yes, 9=Unknown

Write in protocol modification:

Cancer Site or Type

Since your last exam have you had cancer or a tumor? (0=No and skip to next screen; If 1=Yes, 2=Maybe, 9=Unknown please continue)				
Code for table: 0=No, 1=Yes, Cancerous, 2=Maybe, Possible Cancer, 3=Benign, 9=Unknown				
Code	Site of Cancer or Tumor	Year First Diagnosed	Name Diagnosing M.D.	City of M.D.
<input type="checkbox"/>	Esophagus			
<input type="checkbox"/>	Stomach			
<input type="checkbox"/>	Colon			
<input type="checkbox"/>	Rectum			
<input type="checkbox"/>	Pancreas			
<input type="checkbox"/>	Larynx			
<input type="checkbox"/>	Trachea/Bronchus/Lung			
<input type="checkbox"/>	Leukemia			
<input type="checkbox"/>	Skin			
<input type="checkbox"/>	Breast			
<input type="checkbox"/>	Cervix/Uterus			
<input type="checkbox"/>	Ovary			
<input type="checkbox"/>	Prostate			
<input type="checkbox"/>	Bladder			
<input type="checkbox"/>	Kidney			
<input type="checkbox"/>	Brain			
<input type="checkbox"/>	Lymphoma			
<input type="checkbox"/>	Other/Unknown			

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

Physical Exam—Respiratory, Heart, Abdomen

OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

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

Heart		
<input type="checkbox"/>	S3 Gallop	0=No 1=Yes
<input type="checkbox"/>	S4 Gallop	9=Unknown
<input type="checkbox"/>	Systolic Click	0=No, 1=Yes 2=Maybe
<input type="checkbox"/>	Neck vein distention at 90 degrees (sitting upright)	9=Unknown
<input type="checkbox"/> if yes, fill out below	Systolic murmur(s) (0=No, 1=Yes, 2=Maybe, 9=Unknown)	
Murmur Location	Grade 0=No sound 1 to 6 for grade of sound heard 9=Unknown	Type 0=None 1=Ejection 2=Regurgitant 3=Other 9=Unknown
Apex	<input type="checkbox"/>	<input type="checkbox"/>
Left Sternum	<input type="checkbox"/>	<input type="checkbox"/>
Base	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diastolic murmur(s) (0=No, 1=Yes, 2=Maybe, 9=Unknown)	
<input type="checkbox"/> if yes, fill	<input type="checkbox"/>	Valve of origin for diastolic murmur(s) (0=No, 1=Mitral, 2=Aortic, 3=Both, 4=Other, 8=N/A, 9=Unk)

Abdominal Abnormalities		
<input type="checkbox"/>	Liver enlarged	
<input type="checkbox"/>	Surgical scar	0=No 1=Yes
<input type="checkbox"/>	Abdominal aneurysm	2=Maybe
<input type="checkbox"/>	Abdominal bruit	9=Unknown

Comments about respiratory, heart, and abdominal abnormalities

Physical Exam--Peripheral Vessels—Veins and Arterial pulses
OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

Left	Right	Varicosities	
<input type="checkbox"/>	<input type="checkbox"/>	Stem varicose veins (Do not code reticular or spider varicosities)	0=No abnormality 1=Yes 9=Unknown
Left	Right	Lower Extremity Abnormalities	
<input type="checkbox"/>	<input type="checkbox"/>	Ankle edema	(0=No, 1=Yes, 2=Maybe, 8=absent due to amputation 9=Unknown)
<input type="checkbox"/>	<input type="checkbox"/>	Amputation level	(0=No, 1=Toes only, 2=Ankle, 3=Knee, 4=Hip, 8=Not applicable, 9=Unknown)

Comments _____

Artery	Pulse		Bruit	
	(0=Normal, 1=Abnormal, 9=Unknown)		(0=Normal, 1=Abnormal, 9=Unknown)	
	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 _____

Physical Exam--Neurological Exam

OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

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

MD20

Electrocardiograph--Part I

OMB NO=0925-0216 12/31/2007

_ _ _	OFFSITE ONLY
MD Id#	MD Name

Rates and Intervals	
_ _ _	Ventricular rate per minute (999=Unknown)
_ _	P-R Interval (hundredths of a second) (99=Fully Paced, Atrial Fib, or Unknown)
_ _	QRS interval (hundredths of second) (99=Fully Paced, Unknown)
_ _	Q-T interval (hundredths of second) (99=Fully Paced, Unknown)
_ _ _ _	QRS angle (put plus or minus as needed) (e.g. -045 for minus 45 degrees, +090 for plus 90, 9999=Fully paced or Unknown)
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 Unknown)
_	Pattern (1=Left, 2=Right, 3=Indeterminate, 9=Unknown)
_	Complete (QRS interval=.12 sec or greater)(0=No, 1=Yes, 9=Unknown)
_	Incomplete (QRS interval = .10 or .11 sec) (0=No, 1=Yes, 9=Unknown)
_	Hemiblock (0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unknown)
_	WPW Syndrome (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)
Arrhythmias	
_	Atrial premature beats (0=No, 1=Atr, 2=Atr Aber, 9=Unknown)
_	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)

MD21

Electrocardiograph-Part II

OMB NO=0925-0216 12/31/2007

Myocardial Infarction Location	
<input type="checkbox"/>	Anterior (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)
<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 in lead III ≥ 25mm
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 ≥ 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 unknown)
<input type="checkbox"/>	Nonspecific T-wave abnormality (0=No, 1=T inversion, 2=T flattening, 3=Other, 9=Fully paced or unknown)
<input type="checkbox"/>	U-wave present (0=No, 1=Yes, 2=Maybe, 9=Paced or Unknown)
<input type="checkbox"/>	Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unknown)
<input type="checkbox"/>	RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown; If complete RBBB present, RVH=9)
<input type="checkbox"/>	LVH (0=No, 1=LVH with strain, 2=LVH with mild S-T Segment Abn, 3=LVH by voltage only, 9=Fully paced or Unkn, If complete LBBB present, LVH=9)

Comments and
Diagnosis _____

Clinical Diagnostic Impression--Part I

OMB NO=0925-0216 12/31/2007

Heart Diagnoses First Examiner Opinions	
<input type="checkbox"/>	Rheumatic Heart Disease
<input type="checkbox"/>	Aortic Valve Disease
<input type="checkbox"/>	Mitral Valve Disease
<input type="checkbox"/>	Other Heart Disease (includes congenital)
<input type="checkbox"/>	Arrhythmia

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

Peripheral Vascular Disease First Examiner Opinions	
<input type="checkbox"/>	Other Peripheral Vascular Disease
<input type="checkbox"/>	Other Vascular Diagnosis (Specify) _____

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

Neurologic Disease First Examiner Opinions	
<input type="checkbox"/>	Stroke/ TIA
<input type="checkbox"/>	Dementia
<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	Adult Seizure Disorder
<input type="checkbox"/>	Other Neurological Disease (Specify) _____

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

Comments CDI _____

Clinical Diagnostic Impression--Part II

Non Cardiovascular Diagnoses First Examiner Opinions

OMB NO=0925-0216 12/31/2007

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

Comments CDI Diagnoses

MD24

Second Examiner Opinions
OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2nd Examiner ID Number	_____ 2nd Examiner Last Name
--	-------------------------------	-------------------------------------

Coronary Heart Disease Second Examiner Opinions (Provide initiators, qualities, radiation, severity, timing, presence after procedures done)	
<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	Cardiac Syncope
<input type="checkbox"/>	Angina Pectoris
<input type="checkbox"/>	Coronary Insufficiency
<input type="checkbox"/>	Myocardial Infarct

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

Comments about chest and heart disease

Intermittent Claudication Second Examiner Opinions (Provide initiators, qualities, radiation, severity, timing, presence after procedures done)	
<input type="checkbox"/>	Intermittent Claudication

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

Comments about peripheral vascular disease

Cerebrovascular Disease Second Examiner Opinions (Provide initiators, qualities, severity, timing, presence after procedures done)	
<input type="checkbox"/>	Stroke
<input type="checkbox"/>	TIA

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

Comments about possible Cerebrovascular Disease
