Framingham Heart Study
Offspring Examination 8 Forms

Numerical Data--Part I

OMB NO=0925-0216 12/31/2007

Basic Information

|__|__|__|	**Examiner's Number** for Basic Information.		
|__|	**Sex of Participant** (1=Male, 2=Female)		
|__|__|	**Age of Participant (years), 99=Unknown.**		
|__|	**Site of Exam** (0=Heart Study, 1=Nursing home, 2=Residence, 3=Other)		
|__|__|__|	**Weight** (to nearest pound)	|__| **Protocol modification**	0=No 1=Yes
If offsite, fill ☛	|__|	**Method used to obtain weight** (0=FHS protocol/field visit with portable scale, 1=Recorded in NH chart, 2= Other, write in ____________________	
	|__|__|*|__|__|*|__|__|__|__|	**Date weight obtained** (mm/dd/yyyy)	
|__|__|*|__|__|	**Height** (inches, to next lower 1/4 inch)	|__| **Protocol modification**	0=No 1=Yes
|__|	**In the past year, have you lost more than 10 pounds?** 0=No, 1= Yes, unintentionally, NOT due to dieting or exercise 2= Yes, intentionally, due to dieting or exercise		

Regional Anthropometry

(Code boxes below with 9's if not done or unknown)

|__|__|__|	**Examiner's Number** for anthropometry.		
|__|__|*|__|__|	**Waist Girth at umbilicus** (inches, to next lower 1/4 inch)	|__| **Protocol modification**	0=No 1=Yes 8=Offsite
|__|__|*|__|__|	**Waist Girth at iliac crest** (inches, to next lower 1/4 inch)	|__| **Protocol modification**	
|__|__|*|__|__|	**Sagittal abdominal diameter** (to nearest 0.1 cm)	|__| **Protocol modification**	
|__|	**Are you fasting ≥ 8 hours?**		

Comments on **all** protocol modifications:
____
____
____

TECH01

Exam 8 Procedures Sheet

|__|	**Informed Consent Signed**	0=No, 1=Yes, 2=Consent signed, may qualify for waiver 3=Waiver used, 4=Other
|__|	**Anthropometry**	0=No, 1=Yes, 8=Offsite visit
|__|	**Sociodemographic Questions**	
|__|	**SF-12 Health Survey**	
|__|	**CES-D Scale**	
|__|	**Exercise Questionnaire**	
|__|	**Mini-Mental Status Exam**	
|__|	**Urine Specimen**	
|__|	**Blood Draw**	
|__|	**ECG**	
|__|	**Observed performance (**Timed walk hand grip)	
|__|	**Tonometry /ECHO/Carotid**	
|__|	**Ankle-brachial blood pressure by Doppler.**	
|__|	**Spirometry**	
|__|	**Post bronchodilator Spirometry**	
|__|	**Diffusion Capacity**	
|__|__|	**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
|__|__|	**Reason post bronchodilator test not done**	
|__|__|	**Reason Diffusion not done**	

Exit Interview

|__|__|__| **Examiner ID**

|__|	Procedure sheet reviewed	0=No, 1=Yes, 8=Offsite
|__|	Referral sheet reviewed	
|__|	Willett dietary questionnaire provided (if not completed in clinic)	
|__|	Left clinic w/ belongings	
|__|	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)

Keyers: if Second Exam Date is not filled and page is blank' then leave the page all blank.

Fill in with 1=yes if procedure ***was done*** *on the* ***Secon****d 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

|__|	**MD Questionaire.**	
|__|	**Anthropometry**	
|__|	**Sociodemographic Questions**	
|__|	**SF-12 Health Survey**	
|__|	**CES-D Scale**	0=No,
|__|	**Exercise Questionnaire**	
|__|	**Mini-Mental Status Exam**	
|__|	**Urine Specimen**	1=Yes,
|__|	**Blood Draw**	
|__|	**ECG**	
|__|	**Observed performance (**Timed walk hand grip)	
|__|	**Tonometry /ECHO/Carotid**	8=Offsite visit
|__|	**Ankle-brachial blood pressure by Doppler.**	
|__|	**Spirometry**	
|__|	**Post bronchodilator Spirometry**	
|__|	**Diffusion Capacity**	
|__|__|	**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
|__|__|	**Reason post bronchodilator test not done**	
|__|__|	**Reason Diffusion not done**	

TECH02a

Rosow-Breslau Scale

OMB NO=0925-0216 12/31/2007

|__|__|__|	**Examiner's Number** for Socio-demographics

Socio-demographics

|___|	**Where do you live?** (0=Private residence, 1=Nursing home, 2=Other institution, such as: assisted living, retirement community, 9=Unknown
|___|	**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	|___|	Spouse	0=No 1=Yes, less than 3 months per year 2=Yes, more than 3 months per year 9=Unknown
	|___|	Significant Other	
	|___|	Children	
	|___|	Friends	
	|___|	Relatives	

Use of Nursing and Community Services

|__|	**Have you been admitted to a nursing home (or skilled facility) in the past year**)	0=No 1=Yes 9=Unknown
|__|	**In the past year, have you been visited by a nursing service, or used home, community, or outpatient programs?**	

Rosow-Breslau Questions

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

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
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	
|__|	**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;

TECH04

Physical Activity Questionnaire--Framingham Heart Study
Tech-administered

OMB NO=0925-0216 12/31/2007

|__|__|__| **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**

|__|	**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
|__|	**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**

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

TECH06

Nagi Questions

OMB NO=0925-0216 12/31/2007

|__|__|__|	**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

|__|	**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)**

TECH07

Falls/Fractures

OMB NO=0925-0216 12/31/2007

|__|__|__|	**Examiner's Number** for Activities - Part C

Fractures

|__| **Since Your Last Clinic Visit Have You Broken Any Bones?**
(Code: 0=No, 1=Yes, 2=Unsure, 9=Unknown)

If Yes, fill ☛ |__|__| **Location of fracture:**

Location (code unknown as 99)

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

TECH09

Cognitive Tests

TECH10

OMB NO=0925-0216 12/31/2007

Cognitive Tests

Observed performance. Part 1

OMB NO=0925-0216 12/31/2007

|__|__|__|	**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

|__|__|__|	**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=≥300
|__|__|__|	**Right ankle**	999= Unknown or not done
|__|__|__|	**Left ankle**	
|__|__|__|	**Left arm**	

REPEAT SYSTOLIC BLOOD PRESSURE MEASUREMENTS (reverse order)

|__|__|__|	**Left arm**	300=≥300
|__|__|__|	**Left ankle**	999= Unknown or not done
|__|__|__|	**Right ankle**	
|__|__|__|	**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=≥300
|__|__|__|	**Left ankle**	999= Unknown or not done
|__|__|__|	**Right ankle**	
|__|__|__|	**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 Chronic obstructive pulmonary disease	|__|	|__|	|__|__|
Sleep Apnea	|__|	|__|	|__|__|
Pulmonary Fibrosis	|__|	|__|	|__|__|

Inhaler Use

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

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

|__| Start to cough?

|__| Start to wheeze?

|__| Get a feeling of tightness in your chest?

|__| Start to feel short of breath?

|__| Get a runny or stuffy nose or start to sneeze?

|__| Get itching or watering eyes?

0=No
1=Yes

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

|__| Start to cough?

|__| Start to wheeze?

|__| Get a feeling of tightness in your chest?

|__| Start to feel short of breath?

|__| Get a runny or stuffy nose or start to sneeze?

|__| Get itching or watering eyes?

0=No
1=Yes

|__| **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

|__|	**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=Unknown
|__|__|*|__|__|	**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=Unknown)
	Proxy Name ____________________
|__|	**Relationship** (1=1st Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unknown
|__|__|*|__|__|	**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=Unknown)

TECH016

Sociodemographic questions. Part I Self-administered

OMB NO=0925-0216 12/31/2007

|__| **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)

|__|	Hispanic or Latino
|__|	Not Hispanic or Latino

Race: (check ALL that apply)

|__|	Caucasian or white
|__|	African-American or black
|__|	Asian
|__|	Native Hawaiian or other Pacific Islander
|__|	American Indian or Alaska native
|__|	prefer not to answer
|__|	

|__| **What is the highest degree or level of school you have completed?**
(if currently enrolled, mark the highest grade completed, degree received)

0= no schooling
1=grades 1-8
2=grades 9-11
3=completed high school (12th 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

|__| **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
	☐	☐	☐	☐	☐

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	☐	☐	☐
3. Climbing **several** flights of stairs	☐	☐	☐

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	☐	☐
5. Were limited in the **kind** of work or other activities	☐	☐

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	☐	☐
7. Didn't do work or other activities as **carefully** as usual	☐	☐

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
☐	☐	☐	☐	☐

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?	☐	☐	☐	☐	☐	☐
10. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
11. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

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
☐	☐	☐	☐	☐

TECH20

Sleep Questionnaire. Part 1
Self-administered

OMB NO=0925-0216 12/31/2007

|__|__| hours	**How much sleep do you usually get at night (or your main sleep period) on weekdays or work days?** (Number of hours)
|__|__| hours	**How long does it usually take you to fall asleep at bedtime?** (Number of hours, 1=1hour or less)

Sleep Related Symptoms (days/nights)

|__|	**In the past 12 months, how often do you snore while you are sleeping?**	0=Never 1=Rarely(1-2 nights/week) 2=Occasionally(3-4 nights/week) 3=Frequently(5/more nights/week) 9=Don't know
|__|	**In the past 12 months, how often do you snort, gasp, or stop breathing while you are asleep?**	

Please indicate how often in the past month 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

	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	**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
If no (0) or partial (2) ☞	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)

OMB NO=0925-0216 12/31/2007

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 foe measuring)

STUDY QUALITY

Quantitative	**Good**	**Fair**	**Poor**	**Inadequate**
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
Qualititative				
2-D study	~ =1	~ =2	~ =3	~ =4
CW AV	~ =1	~ =2	~ =3	~ =4
Color Doppler	~ =1	~ =2	~ =3	~ =4
Overall study quality	~ =1	~ =2	~ =3	~ =4

Comments:____

____

____

~ Priority MD overread:

~ Severe AS ~ Severe MS ~ Mod-severe __________regurgitation

~ 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**
Other LA comment						
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
Other MV comment						
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
Other AV/AR comment						
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=paradoxic	~ 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
Other LV comment						LVEF __ __%
Right	**~ 0=normal**	**~ 1= prob nl**	**~ 2=abnormal**			**~ 9=unknown**
Heart/Pericardium	~ 0=no	~ 1=borderline	~ 2=mild	~ 3=moderate	~ 4=severe	~ 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						
Other right !/pericardium						
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**
Other Doppler comment						

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** (test was done, even if all 4 pulses could not be acquired and recorded) **no** (test was not attempted or done)	**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** (test was done, even if recorded on video only) **yes, partial** (i.e. only apical OR only parasternal images were acquired) **no** (test was not attempted or done)	**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:	_ **yes** _ **no**	

PAT

Test done?	**yes** (test was done) **yes, partial** (yes, partial test was done but suspect data problems) **no** (test was not attempted or done)	**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

|__| **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
|__|	**Blood Pressure** result ____/_____ mmHg Phone call > 200/110 Expedite ≥ 180/100 Elevated > 140/90
|__|	**Abnormal Urine** result __________ *Write in abnormality*
|__|	**ECG abnormality** ______________________
|__|	**Clinic Physician** ______________________ **identified medical problem**
|__|	**Other** ______________________ ______________________

|__|__|__|	**Technician ID#**
|__|	**Was there an adverse event in clinic/offsite that does not require further medical evaluation?** (0=No, 1=Yes, 9=Unkown) **Comments:**______________________ ______________________
offcite inly **if yes fill ☛**	|__|__|__| Technician ID# (OFFSITE visits only) |__| **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

MD01

Medical History—Medications

OMB NO=0925-0216 12/31/2007

|__| If yes, fill☛	**Take aspirin regularly**? (0=No, 1=Yes, 9=Unk)	
	|__|__|	**Number aspirins taken regularly** (99=Unknown)
	|__|	**Frequency per** (1=Day, 2=Week 3=Month, 4=Year, 9=Unk)
	|__|__|__|	**Usual dose (** 081=baby,160=half dose, 325=nl, 500=extra or larger,999=unk)

|__|	**Since your last exam have you taken medication for hypertension/high blood pressure?** (0=no, 1=yes,now, 2=yes,not now, 9=unk)
|__|	**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)
|__|	**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)
|__|	**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 – Prescription and Non-Prescription Medications

OMB NO=0925-0216 12/31/2007

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

|__| **Medication bottles/packs used by examiner to record medications?** 0=No, 1=Yes

*****List medications taken regularly in past month/ongoing medications*****

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

Continue on the next page ➞

MD03

Medical History—Prescription and Non-Prescription Medications
Continue from screen 3.

OMB NO=0925-0216 12/31/2007

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

*****List medications taken regularly in past month/ongoing medications*****

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

MD04

Medical History–Female Reproductive History. Part 1.

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

If participant is male, leave questions blank

|__| **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

|__| 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**

|__| **2. Have you had a hysterectomy (uterus/womb removed)since your last exam?** (0=no, 1=yes, 9=unknown)

If yes, fill☛

|__|__| Age at hysterectomy?

_ _/_ _ _ _ Date of surgery (mo/yr) Use 4 digits for year 99/9999=Unknown

|__| **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☛

|__|__| 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

|__| **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.)

|__|__| **a) Age when periods stopped** (00=not stopped, 99=unknown) **!** If periods now induced by hormones, code age when periods naturally stopped.

|__| **b) Was your menopause natural or the result of surgery, chemotherapy, or radiation?** (1=natural, 2=surgical, 3=chemo/radiation, 4=other, 9=unknown)

|__| **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☛

|__|__| **What age did you begin hormone replacement therapy?** 99=unknown

|__|__| years |__|__| months **For how long did you take hormones?** 99/99=unknown

|__| **Estrogen use?** (0=no, 1=yes, now, 2=yes, not now, 9=unknown)

If yes, fill☛

_ ______________________ Name of most recent estrogen preparation

|__|__| . |__|__|__| Strength

|__|__| Number of days per month taken

|__| **Progesterone use?** (0=no, 1=yes, now, 2=yes, not now, 9=unknown)

If yes, fill☛

__________________________ Name of most recent progesterone preparation

|__|__| . |__|__| Strength

|__|__| Number of days per month taken

|__| **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)

If yes, fill☛

|__|__|__| **Number of months used?**

|__| **Current use?** (0=no, 1=yes, raloxifene, 2=yes, tamoxifen, 3=yes, other, 9=unknown)

MD06

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?**

If yes, fill☛ | | Do you smoke a pipe or cigar now

0=No
1=Yes
9=Unknown

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. *Code EITHER per week OR per month as appropriate.*		
			Number of drinks	
			Per week **OR** 999=Unk	Per month
|__|	Beer	12oz bottle, glass, can	|__|__|__|	|__|__|__|
|__|	Wine	4oz glass	|__|__|__|	|__|__|__|
|__|	Liquor/spirits	1 _ oz jigger	|__|__|__|	|__|__|__|

|__|__|__|	**At what age did you stop drinking alcohol?** (00= not stopped, 888=never drink99=Unknown)
|__|	**Over the past year, on average on how many days per week did you drink an alcoholic beverage of any type?** (1=1or less, 9=Unknown)
| | |	**Over the past year, on a typical day when you drink, how many drinks do you have?** (99=Unknown)
|__|__|	**What was the maximum number of drinks you had in 24 hr. period during the past month?** (99=Unknown)
|__|	**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

|__| **Do you usually have a cough?** (Exclude clearing of the throat)

|__| **Do you usually have a cough at all on getting up or first thing in the morning?**

0=No
1=Yes
9=Don't know

If **YES** to **either** question above **answer** the following:

|__| 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

|__|__| How many years have you had this cough? (99=Unk.) # of years

Phlegm

|__| **Do you usually bring up phlegm from your chest ?**

|__| **Do you usually bring up phlegm at all on getting up or first thing in the morning?**

0=No
1=Yes
9=Don't know

If **YES** to **either** question above **answer** the following:

|__| 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

|__|__| How many years have you had trouble with phlegm? (99=Unk.) # of years

Wheeze

|__| **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☛

|__| **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

|__| **In the past 12 months, have you had this wheezing or whistling in the chest when you had a cold?**

|__| **In the past 12 months, have you had this wheezing or whistling in the chest apart from colds?**

|__| **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?**

0=No
1=Yes
9=Don't know

MD09

Medical History—Respiratory Symptoms. Part II

OMB NO=0925-0216 12/31/2007

Nocturnal chest symptoms

	Question	Codes
|__|	**In the last 12 months, have you been awakened by shortness of breath?**	0=No 1=Yes 9=Don't know
|__|	**In the last 12 months, have you been awakened by a wheezing/whistling in your chest?**	
|__|	**In the last 12 months, have you been awakened by coughing?**	
if yes, fill all☛ |__|	In the last 12 months, how often have you been awakened by coughing?	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

	Question	Codes
|__|	**Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?**	0=No 1=Yes 9=Don't know
if yes, fill all☛ |__|	Do you have to walk slower than people of your age on level ground because of shortness of breath?	
|__|	Do you ever have to stop for breath when walking at your own pace on level ground?	
|__|	Do you ever have to stop for breath after walking 100 yards (or after a few minutes) on level ground?	
|__|	**Do you/have you needed to sleep on two or more pillows to help you breath?** (Orthopnea)	
|__|	**Since your last exam have you had swelling in both your ankles (ankle edema)?**	
|__|	**Since your last exam have you been told you had heart failure or congestive heart failure?**	
|__|	**Since your last exam have you been hospitalized for heart failure?**	

Examiner's opinion:

	Question	Codes
|__|	**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**
|__|__|__| to nearest 2 mm Hg	|__|__|__| to nearest 2 mm Hg	|__| 0=pedi,1=reg.adult, 2=large adult, 3= thigh, 9=unknown	|__| 0=No, 1=Yes, 9=Unknown

Comments on protocol modification____

____

MD11

Medical History—Chest pain

OMB NO=0925-0216 12/31/2007

|__| **Any chest discomfort** (0=No, 1=Yes, 2=Maybe, 9=Unknown)
(please provide narrative comments in addition to checking the appropriate boxes)

if yes, fill and below

|__| Chest discomfort with exertion or excitement (0=No, 1=Yes, 2=Maybe, 9=Unknown)
|__| Chest discomfort when quiet or resting

Chest Discomfort Characteristics (must have checked box at top of table)

|__|__|*|__|__|__|__|	Date of onset	(mo/yr, Use 4 digits for year, 99/9999=Unknown)
|__|__|__|	Usual duration	(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)
|__|__|__|	Longest duration	(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)
|__|	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)
|__|	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)
|__|__|__|	Frequency (number in past month)	999=Unknown
|__|__|__|	Frequency (number in past year)	999=Unknown
|__|	Type	(1=Pressure, heavy, vise, 2=Sharp, 3=Dull, 4=Other, 9=Unk)
|__|	Relief by Nitroglycerine in <15 minutes	0=No
|__|	Relief by Rest in <15 minutes	1=Yes,
|__|	Relief Spontaneously in <15 minutes	8=Not tried
|__|	Relief by Other cause in <15 minutes	9=Unknown

|__| **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

|__|	**Angina pectoris**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
|__|	**Angina pectoris since revascularization procedure**	
|__|	**Coronary insufficiency**	
|__|	**Myocardial infarct**	

Comments____

____

____

MD12

Medical History—Atrial Fibrillation/Syncope

OMB NO=0925-0216 12/31/2007

|__| **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☛

|__|__|*|__|__|*|__|__|__|__| mm dd yyyy — Date of first episode (99/99/9999=unk) code year as 4 digits, example: Year 1999=1999

|__| ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn)

Hospitalized at:________________________________

M.D. seen: ________________________________

|__| **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. 1998)	(mo/yr, 99/9999=Unknown)
|__|__|__|	Usual duration of loss of consciousness	(minutes, 999=Unkn) 1=1 min or less

|__| **Did you have any injury caused by the event?**(0=No,1=Yes, 2=Maybe,9=Unkn)

|__| **ER/hospitalized or saw M.D.** (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn)

Hospitalized at: ________________________________

M.D. seen: ________________________________

|__| **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☛

|__|__|*|__|__|*|__|__|__|__| mm dd yyyy — Date of serious head injury with loss of consciousness (00/00/0000 =none, 99/99/9999=unk, Use 4 digits for year)

|__| **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☛

|__|__|*|__|__|*|__|__|__|__| mm dd yyyy — Date of most recent seizure (99/99/9999=unk) code four digit year

|__| Are you being treated for a seizure disorder? (0=No, 1=Yes, 2=Maybe, 9=Unknown)

Syncope First Opinions

|__| **Syncope** (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unknown) needs second opinion

|__|	**Cardiac syncope**	(0=No, 1=Yes, 2=Maybe, 9=Unknown)
|__|	**Vasovagal syncope**	
|__|	**Other-Specify: ____________**	

Comments:________________________________

MD13

Medical History—Cerebrovascular, Neurological and Venous Diseases

OMB NO=0925-0216 12/31/2007

Cerebrovascular Episodes Since Your Last Exam

|__|	**Sudden muscular weakness**	Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	**Sudden speech difficulty**	
|__|	**Sudden visual defect**	
|__|	**Sudden double vision**	
|__|	**Sudden loss of vision in one eye**	
|__| **if yes, fill ☛**	**Sudden numbness, tingling**	
	|__| Numbness and tingling is positional	
|__|	**Head CT or MRI scan** date ___-___-______ place ______________________________	0=No,1=Yes, 2=both,9=Unkn.
|__|	**Seen by neurologist**(write in who and when below)	Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	**Have you been told by a doctor you had a stroke or TIA (transient ischemic attack, mini-stroke)?**	
|__|	**Have you been told by a doctor you have Parkinson Disease?**	
|__|	**Have you been told by a doctor you have memory problems, dementia or Alzheimer's disease?**	
|__|	**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

|__|		**TIA or stroke took place**	0=No, 1=Yes, 2=Maybe, 9=Unkn
if yes or maybe fill ☛	|__|__|*|__|__|__|__|	**Date** (mo/yr, Use 4 digits for year, 99/9999=Unkn) Observed by________________________	
	|__|__|*|__|__|*|__|__|	**Duration** (use format days/hours/mins, 99/99/99=Unknown)	
	|__|	**Hospitalized or saw M.D.** (0=No, 1=Hosp.2=Saw M.D, 9=Unk) Name______________________________ Address______________________________	

Neurology Comments____

____

Venous Disease

|__|	**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
|__|	**Since your last exam have you had a Pulmonary Embolus** (blood clot in lungs)	

MD14

Medical History--Peripheral Arterial Disease

OMB NO=0925-0216 12/31/2007

Peripheral Arterial Disease

|__| **Do you have discomfort in your legs while walking?** (0=No, 1=Yes, 9=Unkn)

if yes, fill ☛

|__|__| **If walking on level ground, how many city blocks until symptoms develop** (00=no, 99=unknown) where 10 blocks=1 mile, code as no if more than 98 blocks required to develop symptoms

|__|__|__|__| **Year symptoms started** (Use 4 digits for year ,00=no, 9999=unkn)

Left	Right	**Claudication symptoms (0=No, 1=Yes, 9=Unkn)**
|__|	|__|	Discomfort in calf while walking
|__|	|__|	Discomfort in lower extremity (not calf) while walking
|__|		Occurs with first steps (code worse leg)
|__|		After walking a while (code worse leg)
|__|		Related to rapidity of walking or steepness
|__|		Forced to stop walking
|__|__|		Time for discomfort to be relieved by stopping (minutes) (00=No relief with stopping, 88=Not Applicable, 99=Unknown)
|__|__|		Number of days/month of lower limb discomfort (00=No,88=N/A,99=Unk.)

|__| **Have you had back pain in the past 12 month?** — 0=No, 1=all days, 2=most of the days, 3=some days, 4=a few days

if yes, fill ☛

|__| **What happens to back and any leg pain that goes with it when you walk?**

|__| **What happens to back and any pain that goes with it when you sit?**

(0=no change, 1=gets worse, 2=gets better, 9=Unknown)

|__| **Have you ever been told by a doctor you have intermittent claudication or peripheral arterial disease ?**

|__| **Has a doctor ever told you you had spinal stenosis?**

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

if yes, fill ☛

|__| **Have you had a CT or MRI of your spine?**
Date__-__-____ Location ______________________________

PAD First Opinion

|__| **Intermittent Claudication** — 0=No, 1=Yes, 2=Maybe,9=Unkn.

Comments Peripheral Vascular Disease / Venous Disease____

____

MD15

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)**
|__| **if yes** **fill**☛	**Heart Valvular Surgery** |__|__|__|__| Year done (9999-Unk) Location and description____________________
|__| **if yes** **fill**☛	**Exercise Tolerance Test** |__|__|__|__| Year done (9999-Unk) Location____________________
|__| **if yes** **fill**☛	**Coronary arteriogram** |__|__|__|__| Year done (9999-Unk)
|__| **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)
|__| **if yes** **fill**☛	**Coronary bypass surgery** |__|__|__|__| Year done (9999-Unk)
|__| **if yes** **fill**☛	**Permanent pacemaker insertion** |__|__|__|__| Year done (9999-Unk)
|__| **if yes** **fill**☛	**AICD** |__|__|__|__| Year done (9999-Unk)
|__| **if yes** **fill**☛	**Carotid artery surgery/stent** |__|__|__|__| Year done (9999-Unk)
|__| **if yes** **fill**☛	**Thoracic aorta surgery** |__|__|__|__| Year done (9999-Unk)
|__| **if yes** **fill**☛	**Abdominal aorta surgery/stent** |__|__|__|__| Year done (9999-Unk)
|__| **if yes** **fill**☛	**Femoral or lower extremity surgery/stent/angioplasty** |__|__|__|__| Year done (9999-Unk)
|__| **if yes** **fill**☛	**Lower extremity amputation** |__|__|__|__| Year done (9999-Unk)
|__| **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:____

____

MD16

OMB NO=0925-0216 12/31/2007

Physician Blood Pressure
(second reading)

Systolic	Diastolic	BP cuff size	Protocol modification
|__|__|__| to nearest 2 mm Hg 999=Unknown	|__|__|__| to nearest 2 mm Hg 999=Unknwon	|__| 0=pedi,1=reg.adult, 2=large adult, 3= thigh, 9=Unknown	|__| 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.
|__|	**Esophagus**			
|__|	**Stomach**			
|__|	**Colon**			
|__|	**Rectum**			
|__|	**Pancreas**			
|__|	**Larynx**			
|__|	**Trachea/Bronchus/Lung**			
|__|	**Leukemia**			
|__|	**Skin**			
|__|	**Breast**			
|__|	**Cervix/Uterus**			
|__|	**Ovary**			
|__|	**Prostate**			
|__|	**Bladder**			
|__|	**Kidney**			
|__|	**Brain**			
|__|	**Lymphoma**			
|__|	**Other/Unknown** ______________			

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

MD17

Physical Exam—Respiratory, Heart, Abdomen

OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

Respiratory		
|__|	**Wheezing on auscultation**	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	**Rales**	
|__|	**Abnormal breath sounds**	

Heart					
|__|	**S3 Gallop**				0=No 1=Yes 9=Unknown
|__|	**S4 Gallop**				
|__|	**Systolic Click**				0=No, 1=Yes 2=Maybe 9=Unknown
|__|	**Neck vein distention at 90 degrees** (sitting upright)				
|__| **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	**Radiation** 0=None 1=Axilla 2=Neck 3=Back 4=Rt. chest 9=Unknown	**Origin** 0=None, indet. 1=Mitral 2=Aortic 3=Tricuspid 4=Pulm 9=Unknown	
Apex	|__|	|__|	|__|	|__|	
Left Sternum	|__|	|__|	|__|	|__|	
Base	|__|	|__|	|__|	|__|	
|__|	**Diastolic murmur(s)** (0=No, 1=Yes, 2=Maybe, 9=Unknown)				
if yes, fill ☛	|__|	Valve of origin for diastolic murmur(s) (0=No, 1=Mitral, 2=Aortic, 3=Both, 4=Other, 8=N/A, 9=Unk)			

Abdominal Abnormalities		
|__|	**Liver enlarged**	0=No 1=Yes 2=Maybe 9=Unknown
|__|	**Surgical scar**	
|__|	**Abdominal aneurysm**	
|__|	**Abdominal bruit**	

Comments about respiratory, heart, and abdominal abnormalities

____

____

____

MD18

Physical Exam--Peripheral Vessels—Veins and Arterial pulses

OFFSITE VISIT – leave page BLANK

OMB NO=0925-0216 12/31/2007

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

Comments____

____

Artery	Pulse (0=Normal, 1=Abnormal, 9=Unknown)		Bruit (0=Normal, 1=Abnormal, 9=Unknown)	
	Left	Right	Left	Right
Femoral	|__|	|__|	|__|	|__|
Popliteal			|__|	|__|
Post Tibial	|__|	|__|		
Dorsalis Pedis	|__|	|__|		

Comments____

____

____

MD19

Physical Exam--Neurological Exam

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OMB NO=0925-0216 12/31/2007

Neurological Exam			
Left	**Right**		
|__|	|__|	**Carotid Bruit**	Coding (0=No, 1=Yes, 2=Maybe, 9=Unknown)
|__|		**Speech disturbance**	
|__|		**Disturbance in gait**	
|__|		**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 (hundreths of a second)** (99=Fully Paced, Atrial Fib, or Unknown)
|__|__|	**QRS interval (hundreths of second)** (99=Fully Paced, Unknown)
|__|__|	**Q-T interval (hundreths 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)
if yes, fill ☛	|__| **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

|__| **Anterior**

|__| **Inferior**

|__| **True Posterior**

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

Left Ventricular Hypertrophy Criteria

|__| **R > 20mm in any limb lead**

|__| **R > 11mm in AVL**

|__| **R in lead I plus S in lead III ≥ 25mm**

(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)

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**

|__| **S≥ 25mm**

|__| **R or S ≥ 30mm**

|__| **R + S ≥ 35mm**

|__| **Intrinsicoid deflection ≥ .05 sec**

|__| **S-T depression (strain pattern)**

(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)

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 unknown)**

|__| **Nonspecific T-wave abnormality (0=No, 1=T inversion, 2=T flattening, 3=Other, 9=Fully paced or unknown)**

|__| **U-wave present (0=No, 1=Yes, 2=Maybe, 9=Paced or Unknown)**

|__| **Atrial enlargement (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unknown)**

|__| **RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown; 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 Unkn, If complete LBBB present, LVH=9)**

Comments and Diagnosis____

____

MD22

Clinical Diagnostic Impression--Part I

OMB NO=0925-0216 12/31/2007

Heart Diagnoses First Examiner Opinions		
|__|	Rheumatic Heart Disease	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	Aortic Valve Disease	
|__|	Mitral Valve Disease	
|__|	Other Heart Disease (includes congenital)	
|__|	Arrhythmia	

Peripheral Vascular Disease First Examiner Opinions		
|__|	Other Peripheral Vascular Disease	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	Other Vascular Diagnosis (Specify)_______________	

Neurologic Disease First Examiner Opinions		
|__|	Stroke/ TIA	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	Dementia	
|__|	Parkinson's Disease	
|__|	Adult Seizure Disorder	
|__|	Other Neurological Disease (Specify)_______________	

Comments CDI ____

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MD23

Clinical Diagnostic Impression--Part II

Non Cardiovascular Diagnoses First Examiner Opinions

OMB NO=0925-0216 12/31/2007

	Endocrine	
|__|	**Thyroid Disease**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Diabetes Mellitus**	
|__|	**Other endocrine disorders,** specify__________________________	
	GU/GYN	
|__|	**Renal disease,** specify______________________________________	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Prostate disease**	
|__|	**Gynecologic problems,** specify__________________________	
	Pulmonary	
|__|	**Emphysema**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Pneumonia**	
|__|	**Asthma**	
|__|	**Other pulmonary disease,** specify___________________________	
	Rheumatologic Disorders	
|__|	**Gout**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Degenerative joint disease**	
|__|	**Rheumatoid arthritis**	
|__|	**Other musculoskeletal or connective tissue disease,**specify________	
	GI	
|__|	**Gallbladder disease**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**GERD/ulcer disease**	
|__|	**Liver disease**	
|__|	**Other GI disease,** specify____________________________________	
	Blood	
|__|	**Hematologic disorder**	**0=No, 1=Yes, 2=Maybe, 9=Unk**
|__|	**Bleeding disorder**	
	Other	
|__|	**Eye**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**ENT**	
|__|	**Skin**	
|__|	**Other,** specify____	
	Infectious Disease	
|__|	If Yes, specify____ ____	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
	Mental Health	
|__|	**Depression**	**0=No, 1=Yes, 2=Maybe, 9=Unknown**
|__|	**Anxiety**	
|__|	**Psychosis**	
|__|	**Other,** specify____	

Second Examiner Opinions

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|__|__|__|	**2nd Examiner ID Number**	____________________ **2nd Examiner Last Name**

Coronary Heart Disease Second Examiner Opinions (Provide initiators, qualities, radiation, severity, timing, presence after procedures done)		
|__|	**Congestive Heart Failure**	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	**Cardiac Syncope**	
|__|	**Angina Pectoris**	
|__|	**Coronary Insufficiency**	
|__|	**Myocardial Infarct**	

Comments about chest and heart disease

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Intermittent Claudication Second Examiner Opinions (Provide initiators, qualities, radiation, severity, timing, presence after procedures done)		
|__|	**Intermittent Claudication**	0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments about peripheral vascular disease

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Cerebrovascular Disease Second Examiner Opinions (Provide initiators, qualities, severity, timing, presence after procedures done)		
|__|	**Stroke**	0=No, 1=Yes, 2=Maybe, 9=Unknown
|__|	**TIA**	

Comments about possible Cerebrovascular Disease

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