ID: «Idtype» - «Id»

Numerical Data/Anthropometry

☐ Check here if whole page is blank. Reason why_____

|__|__|__| **Technician Number** (for basic information)

Basic Information

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

Anthropometry

Check Protocol Modification *ONLY if there was one and document it in Comment section*

88*88=Refused, 99*99=Not done or Unk.

|__|__|*|__|__| **Height** *(inches, to next lower 1/4 inch)*

☐ **Protocol modification**

|__|__|__| **Weight** *(to nearest pound)* (400=400 or more 888=refused, 999=Unk.)

☐ **Protocol modification**

|__| **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

|__|__|__| **Technician Number** (for anthropometry)

|__|__|*|__|__| **Neck Circumference** *(inches, to next lower1/4 inch)*

☐ **Protocol modification**

|__|__|*|__|__| **Waist Girth at umbilicus** *(inches, to next lower 1/4 inch).*

☐ **Protocol modification**

|__|__|*|__|__| **Hip Girth** *(inches, to next lower 1/4 inch)*

☐ **Protocol modification**

|__|__|*|__|__| **Thigh Girth** *(inches, to next lower 1/4 inch)*

☐ **Protocol modification**

Comments for ALL Protocol Modification *(specify measurement)*

_____

_____

TECH01

☐ Check here if whole page is blank. Reason why_____

Procedures Sheet

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

|__| **Type of Exam**	1=Complete exam, 2=Split exam(exam completed in 2 visits), 3=short exam (incomplete exam), 8=offsite
|__| **Informed Consent Signed**	0=No, 1=Yes, 2= offspring waiver of consent, LAR, or next-of-kin
|__| **Urine Specimen**	
|__| **Blood Draw**	
|__| **Mini-Mental Status Exam**	
|__| **Anthropometry**	
|__| **Sociodemographic Questions** (self administered)	
|__| **SF-12 Health Survey**	
|__| **CES-D Scale**	
|__| **NAGI, Rosow-Breslau, Katz**	
|__| **Exercise Questionnaire**	
|__| **ECG**	
|__| **P Wave Signal Averaged ECG**	
|__| **If not performed why:** 1=AF, 2=Pacemaker, 3=Pat. ran out of time, 4=Pat. couldn't lie flat, 5=equipment malfunction, 6=other	
|__| **Observed performance (**Timed walk, hand grip, chair stands)	
|__| **Tonometry**	
|__| **Ankle-brachial blood pressure by Doppler.** *(Participants ≥ 40 years)*	
|__| **Spirometry**	0=Not Done, 1=Done, 2=Attempted, not finished, 3= Attempted, tech aborted ,4=Other
|__| **Reason Spirometry not done**	1=Medical exclusion, 2=Refused, 3=equipment problems 4=Other
|__| **Post Albuterol Spirometry**	0=Not Done, 1=Done, 2=Attempted, not finished, 3= Attempted, tech aborted ,4=Other
|__| **Reason Post Alb. Spir. not done**	1=Medical exclusion, 2=Refused, 3=equipment problems 4=Other 5=Do not qualify
|__| **Diffusion Capacity**	0=Not Done, 1=Done, 2=Attempted, not finished, 3= Attempted, tech aborted ,4=Other
|__| **Reason Diffusion not done**	1=Medical exclusion, 2=Refused, 3=equipment problems 4=Other
|__| **Accelerometer**	

TECH02

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

|__|__|*|__|__|*|__|__|__|__|	**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 **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.*

Procedures Sheet

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

|__|	**Type of Exam**	1=Complete exam, 2=Split exam(exam completed in 2 visits), 3=short exam (incomplete exam), 8=offsite
|__|	**Urine Specimen**	
|__|	**Blood Draw**	
|__|	**Mini-Mental Status Exam**	
|__|	**Anthropometry**	
|__|	**Sociodemographic Questions** (self administered)	
|__|	**SF-12 Health Survey**	
|__|	**CES-D Scale**	
|__|	**NAGI, Rosow-Breslau, Katz**	
|__|	**Exercise Questionnaire**	
|__|	**ECG**	
|__|	**P Wave Signal Averaged ECG**	
|__|	**If not performed why:** 1=AF, 2=Pacemaker, 3=Pat. ran out of time, 4=Pat. couldn't lie flat, 5=equipment malfunction, 6=other	
|__|	**Observed performance (**Timed walk, hand grip, chair stands)	
|__|	**Tonometry**	
|__|	**Ankle-brachial blood pressure by Doppler.** *(Participants ≥ 40 years)*	
|__|	**Spirometry**	0=Not Done, 1=Done, 2=Attempted, not finished, 3= Attempted, tech aborted ,4=Other
|__|	**Reason Spirometry not done**	1=Medical exclusion, 2=Refused, 3=equipment problems 4=Other
|__|	**Post Albuterol Spirometry**	0=Not Done, 1=Done, 2=Attempted, not finished, 3= Attempted, tech aborted ,4=Other
|__|	**Reason Post Alb. Spir. not done**	1=Medical exclusion, 2=Refused, 3=equipment problems 4=Other 5=Do not qualify
|__|	**Diffusion Capacity**	0=Not Done, 1=Done, 2=Attempted, not finished, 3= Attempted, tech aborted ,4=Other
|__|	**Reason Diffusion not done**	1=Medical exclusion, 2=Refused, 3=equipment problems 4=Other
|__|	**Accelerometer**	

TECH03

☐ Check here if whole page is blank. Reason why_____

Exit Interview

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

|__| **Procedure sheet reviewed**

|__| **Referral sheet reviewed**

|__| **Left clinic w/ belongings**

0=No
1=Yes
8=Offsite
9=Unk.

|__| **Dietary questionnaire provided** 1=Brought to exam completed or filled out in clinic, 2=Given in clinic to complete at home and send back, 3=Other, 8=Offsite, 9=Unk.

|__| **Left clinic with accelerometer** 0=No, refused, 1=Yes, 2=it will be mailed to them, 8=Offsite, 9=Unk.

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

Comments_____

_____

_____

CLINIC visit only

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

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

OFFSITE visit only

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

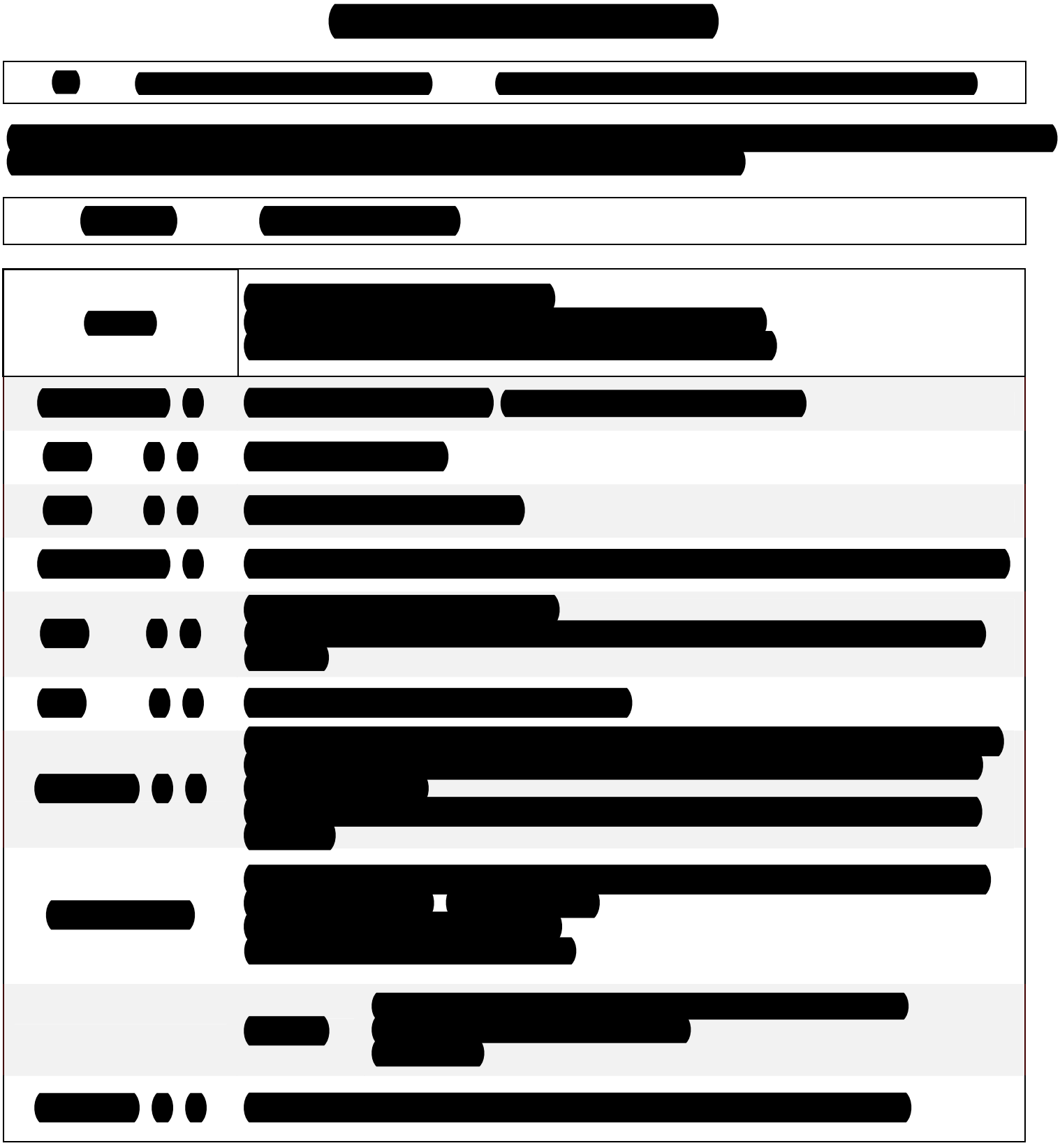
|__| **Was a FHS physician contacted during the examination due to adverse exam finding?** (0=No, 1=Yes, 9=Unk.)
Comments:_____
_____

|__|__|__| **Technician who reviewed TECH portion of exam**

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

TECH04

Cognitive Tests



TECH05

Cognitive Tests

[redacted]

TECH06

Cognitive Tests

[redacted]

Socio-demographic Questionnaire
(Tech-administered)

☐ Check here if whole page is blank. Reason why_____

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

Socio-demographics

|__| **Where do you live?** (0=Private residence, 1=Nursing home, 2=Other, setting (no longer able to live independently) such as assisted living, 9=Unk.)

|__| **Does anyone live with you?** (0=No, 1=Yes, 9=Unk.)
Code Nursing Home Residents as NO

If Yes, fill ☞

If 0 or 9, skip to next table

|__|	Spouse	0=No
|__|	Significant Other	1=Yes, more than 3 months per year
|__|	Children	2=Yes, less than 3 months per year
|__|	Friends	9=Unk.
|__|	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=Unk.
|__|	**In the past year, have you been visited by a nursing service, or used home, community, or adult day care programs?** (examples: home health aide, visiting nurses, etc)	

TECH07

Nagi Questions

(Tech-administered)

☐ Check here if whole page is blank. Reason why_____

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

Nagi Questions

For each activity 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 Physician or Health Care Provider Orders
(6) Don't Know
(9) Unk.

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

TECH08

Rosow-Breslau Scale and Katz Activities of Daily Living
(Tech-administered)

☐ Check here if whole page is blank. Reason why_____

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

Rosow-Breslau Questions

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

Katz ADLs

During the Course of a Normal Day, can you do the following activities independently or do you need help from another person or use special equipment or a device?
0=No help needed, independent,
1=Uses device, independent,
2=Human assistance needed, minimally dependent,
3=Dependent,
4=Does not do during a normal day,
9=Unk.

|__| **Dressing** (undressing and redressing) *Devices such as: velcro, elastic laces*
|__| **Bathing** (including getting in and out of tub or shower) *Devices such as: bath chair, long handled sponge, hand held shower, safety bars*
|__| **Eating** *Devices such as: rocking knife, spork, long straw, plate guard.*
|__| **Transferring**(getting in and out of a chair) *Devices such as: sliding board, grab bars, special seat*
|__| **Toileting Activities** (using bathroom facilities and handle clothing) *Devices such as: special toilet seat, commode*

TECH09

Fractures

☐ Check here if whole page is blank. Reason why_____

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

Fractures

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

If Yes, fill ☞

|__|__| **Location of fracture:**

|__|__| **Location of second fracture** (if more than one)**:**

|__|__| **Location of third fracture** (if more than two)**:**

Code for Location (*code Unk. 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_____

TECH10

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

☐ Check here if whole page is blank. Reason why_____

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

Rest and Activity for a Typical Day over the past year (A typical day = most days of the week) (*Activities must equal 24 hours*)	**Number of hours**
Sleep - Number of hours that you typically sleep?	_____
Sedentary - Number of hours typically sitting? Such as reading, watching TV, using the computer, doing handcrafts	_____
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**

|__| **Over the past 7 days, how often did you participate in SITTING ACTIVITIES such as reading, watching TV, using the computer, or doing handcrafts?**

0 = Never
1 = Seldom/1-2 days
2 = Sometimes/3-4 days
3 = Often/5-7 days
8 = refused
9 = Don't know/Unknown

|__| **Over the past 7 days, how many hours per day did you engage in these sitting activities?**

1 = less than 1 hour
2 = 1 hour but less than 2 hours
3 = 2-4 hours
4 = more than 4 hours
8 = refused
9 = Don't know/Unknown

TECH11

Physical Activity Questionnaire Part 2--Framingham Heart Study

Tech-administered

☐ Check here if whole page is blank. Reason why_____

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

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

	During the past year did you (do)? 0=No, 1=Yes, 8=Refused, 9=Unk.	**In a typical 2 week period of time, how often do you** *(name of activity)*	**Average time/session** hours	**Average time/session** minutes	**Number months/year** 0-12
|__|	**Walk** *(walking to work, walking the dog, walking in the mall)*	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Calisthenics/general exercise** (yoga, pilates)	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Exercise cycle, ski or stair machine** (*treadmill, elliptical, stair master, etc.)*	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Exercises to increase muscle strength or endurance -Weight training** *(free weights, machines)*	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Moderate/strenuous household chores** *(vacuuming, scrubbing floors, washing windows, carrying wood)*	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Jog**	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Bike**	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Dance**	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Aerobics**	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Swim**	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Tennis**	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Golf (no cart)**	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Lawn work or yard care*** *(Mowing the lawn, snow or leaf removal)*	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Outdoor Gardening**	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Hike**	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Light sport or recreational activities** *(bowling, golf with a cart, shuffleboard, fishing, ping-pong)*	|__|__|	|__|__|	|__|__|	|__|__|
|__|	**Other*, write in**_____ _____	|__|__|	|__|__|	|__|__|	|__|__|

TECH12

CES-D Scale
Tech-administered

☐ Check here if whole page is blank. Reason why_____

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

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

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

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

TECH13

Proxy form

☐ Check here if whole page is blank. Reason why_____

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

	Proxy Name _____
|__|	**Relationship** (1=1st Degree Relative(spouse, child), 2=Other Relative, 3=Friend, 4=Health Care Professional, 5=Other, 9=Unk.
|__|__|*|__|__|	**How long have you known the participant?** (Years, months; 99.99=Unk.) example: 3 m=00*03
|__|	**Are you currently living in the same household with the participant?** (0=No, 1=Yes, 9=Unk.)
|__|	**How often did you talk with the participant during the prior 11 months?** (1=Almost every day, 2=Several times a week, 3=Once a week, 4=1 to 3 times per month, 5=Less than once a month, 9=Unk.)

TECH014

Observed performance Part 1
Technician Administered

☐ Check here if whole page is blank. Reason why_____

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

HAND GRIP TEST *Measured to the nearest kilogram*		
Right hand		
Trial 1	99=Unk.	|__|__|
Trial 2	99=Unk.	|__|__|
Trial 3	99=Unk.	|__|__|
Left hand		
Trial 1	99=Unk.	|__|__|
Trial 2	99=Unk.	|__|__|
Trial 3	99=Unk.	|__|__|

☐ **Check if this test not completed or not attempted.**
|__| **If not attempted or completed, why not?** 1=Physical limitation, 2=Refused, 3=Other _____write in, 9=Unk.

Protocol modification for Hand Grip , Chair stands and Walk testing
☐ **Check for Protocol modification**

Comments: _____

_____

_____

_____

TECH15

Observed performance Part 2
Technician Administered

☐ Check here if whole page is blank. Reason why_____	
|__|__|__|	**Technician Number**

Repeated Chair Stands (5)

Time to complete five stands in seconds (99.99=Unk.) |__|__|*|__|__|

If less than five stands, enter the number (9=Unk.) |__|

IF OFFSITE visit, Chair height (in inches, 99*99=Unk.) |__|__|*|__|__|

☐ **Check if this test not completed or not attempted.**

|__| **If not attempted or completed, why not?**
(1=Physical limitation, 2=Refused, 3=Other _____write in, 9=Unk.)

Measured Walks

Walking aid used: 0=No aid, 1=Cane, 2=Walker, 3=Wheelchair, 4=Other, 9=Unk. |__|

First Walk

Walk time (in seconds, 99.99=Unk.) |__|__|*|__|__|

Laser walk time (in seconds, 99.99=Unk.) |__|__|*|__|__|

☐ **Check if this test not completed or not attempted.**

|__| **If not attempted or completed, why not?**
(1=Physical limitation, 2=Refused, 3=Other _____write in, 9=Unk.)

Second Walk

Walk time (in seconds, 99.99=Unk.) |__|__|*|__|__|

Laser walk time (in seconds, 99.99=Unk.) |__|__|*|__|__|

☐ **Check if this test not completed or not attempted.**

|__| **If not attempted or completed, why not?**
(1=Physical limitation, 2=Refused, 3=Other _____write in, 9=Unk.)

Quick Walk

Walk time (in seconds, 99.99=Unk.) |__|__|*|__|__|

Laser walk time (in seconds, 99.99=Unk.) |__|__|*|__|__|

☐ **Check if this test not completed or not attempted.**

|__| **If not attempted or completed, why not?**
(1=Physical limitation, 2=Refused, 3=Other _____write in, 9=Unk.)

Ankle Brachial Blood Pressure Measurements. Participants ≥40 years

☐ Check here if whole page is blank Reason why_____

.|__|__|__| **Technician Number** for Doppler Ankle Brachial Blood Pressure.

|__| **Have you had any problems with blood clots in your legs?** 0=No 1=Yes

If yes, fill ☞ ***do NOT proceed with testing in the extremity with the blood clot***

|__| **Are you being treated for this problem now?**

|__| **Cuff size, arm**
|__| **Cuff size, ankle**
0= pediatric, 1= regular adult
2= large adult, 3= thigh

|__|__|__| **Right arm**
|__|__|__| **Right ankle**
|__|__|__| **Left ankle**
|__|__|__| **Left arm**
300=≥300 mmHg
888= Not Done
999= Unk.

REPEAT SYSTOLIC BLOOD PRESSURE MEASUREMENTS (reverse order)

|__|__|__| **Left arm**
|__|__|__| **Left ankle**
|__|__|__| **Right ankle**
|__|__|__| **Right arm**
300=≥300 mmHg
888= Not Done
999= Unk.

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

|__|__|__| **Right arm**
|__|__|__| **Right ankle**
|__|__|__| **Left ankle**
|__|__|__| **Left arm**
300=≥300 mmHg
888= Not Done
999= Unk.

|__| **Right Ankle blood pressure site**
|__| **Left Ankle blood pressure site**
0= posterior tibial (ankle)
1= dorsalis pedis (foot), 8=Not Done

EXCLUSIONS:

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

Right	Left	
|__|	|__|	**Lower Extremity Exclusions** 1= venous stasis ulceration, or DVT 2= amputation, 3= other_____
|__|	|__|	**Upper Extremity Exclusions** 1=Mastectomy, 3= Other_____

☐ **Check if Protocol modification,** write in_____

Comments _____

_____

TECH17

Respiratory Disease Questionnaire Part 1
Technician Administered

DATE of last exam *«Lexam»*

DATE of last medical history update *«Lupdate»*

☐ Check here if whole page is blank. Reason why_____

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

Respiratory Diagnoses

|__| **Have you ever had asthma?** (0=No, 1=Yes, 9=Unk.)

If yes, fill ☞

- |__| **Do you still have it?**
- |__| **Was it diagnosed by a doctor or other health care professional?**
- |__|__| **At what age did it start?** *(Age in years 88=N/A, 99=Unk.*
- |__|__| **If you no longer have it, at what age did it stop?** *(Age in years) 88=still have it, 99=Unk.*
- |__| **Have you received medical treatment for this in the past 12 months?**

|__| **Have you ever had hay fever** (allergy involving the nose and/or eyes)**?** (0=No, 1=Yes, 9=Unk.)

If yes, fill ☞

- |__| **Do you still have it?** (0=No, 1=Yes, 9=Unk.)

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

- |__| **Chronic Bronchitis**
- |__| **Emphysema**
- |__| **COPD** (Chronic obstructive pulmonary disease)
- |__| **Sleep Apnea**
- |__| **Pulmonary Fibrosis**

Inhaler Use (0=No, 1=Yes)

|__| **Do you take inhalers or bronchodilators?**

If yes, fill ☞

- |__| **Do you take any of the inhaled medications**?- albuterol, ProAir, Proventil, Ventolin, pirbuterol, Maxair, levalbuterol, Xopenex, metaproterenol, Alupent, or ipratropium, Atrovent, Combivent

  If yes, fill ☞ |__|__| How many hours ago did you last use the medication, either by inhaler or nebulizer? *if last used >48 hrs ago code 88, 99= Unk.* **Time in hours 1-48**

- |__| **Do you take any of the following inhaled medications?** salmeterol, Serevent, Advair, formoterol, Foradil, Symbicort, arformoterol, Brovana, tiotropium, or Spiriva,

  If yes, fill ☞ |__|__| How many hours ago did you last use the medication, either by inhaler or nebulizer? *if last used >48 hrs ago code 88, 99=Unk.* **Time in hours 1-48**

TECH18

Respiratory Disease Questionnaire Part 2
Technician Administered

☐ Check here if whole page is blank. Reason why_____

Acute Respiratory Illnesses Since Last Exam

Since your last exam or medical history update

|__| **Have you been hospitalized because of breathing trouble or wheezing?** (0=No, 1=Yes, 9=Unk.)

If yes, fill ☞

|__|__| **How many times has this occurred?**

|__| **Were any of these hospitalizations due to a lung or bronchial problem, for example COPD, asthma, bronchitis, emphysema, or pneumonia?** (0=No, 1=Yes, 9=Unk.)

|__| **Have you required an emergency room visit or an unscheduled visit to a doctor's office or clinic because of breathing trouble or wheezing?** (0=No, 1=Yes, 9=Unk.)

If yes, fill ☞

|__|__| **How many times has this occurred?**

|__| **Were any of these emergency room or unscheduled visits due to a lung or bronchial problem, for example COPD, asthma, bronchitis, emphysema, or pneumonia?** (0=No, 1=Yes, 9=Unk.)

|__| **Have you had pneumonia (including bronchopneumonia)?** (0=No, 1=Yes, 9=Unk.)

If yes, fill ☞

|__|__| **How many times have you had pneumonia?**

The following questions are about problems which occur when you **DO NOT** have a cold or the flu. Please list problems that occurred IN THE PAST 12 MONTHS only

|__| **Have you had a problem with sneezing or a runny or blocked nose when you DID NOT have a cold or the flu?** (0=No, 1=Yes, 9=Unk.)

If yes, fill ☞

|__| **Has this nose problem been accompanied by itchy-watery eyes?** (0=No, 1=Yes, 9=Unk.)

In which of the months did this nose problem occur? (0=No, 1=Yes) *Fill in ALL months.*

|__| January	|__| July
|__| February	|__| August
|__| March	|__| September
|__| April	|__| October
|__| May	|__| November
|__| June	|__| December

TECH19

Sociodemographic questions.
Self-administered (Offsite - tech-administered)

|__|__|__| **Technician Number** for OFFSITE visit ONLY

What is your current marital status? *(check ONE)*

☐ 1	single/never married
☐ 2	married/living as married/living with partner
☐ 3	separated
☐ 4	divorced
☐ 5	widowed
☐ 9	prefer not to answer

Please choose which of the following best describes your current employment status? *(check ONE)*

☐ 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
☐ 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

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?**

TECH20

Medication Questionnaire

Self-administered (Offsite - tech-administered)

☐	**Check if NO medication taken and leave the page BLANK**

This questionnaire refers to medication recommended to you by your doctor or health care provider. For the question below, please check YES or NO

☐ **YES**	☐ **NO**	**Did you ever forget to take your medicine?**
☐ **YES**	☐ **NO**	**Are you careless at times about taking your medicine?**
☐ **YES**	☐ **NO**	**When you feel better do you stop taking your medicine?**
☐ **YES**	☐ **NO**	**Sometimes if you feel worse when you take the medicine, do you stop taking it?**

How often do you forget to take your medicine? *(Circle only ONE)*	
1.	Never
2.	More than once per week
3	Once per week
4.	More than once per month
5.	Once per month
6.	Less than once per month.

TECH21

SF-12® Health Survey (Standard)

Self-administered

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

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

---

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

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

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	☐	☐

TECH22

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

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

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

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
☐	☐	☐	☐	☐

TECH23

Sleep Questionnaire. Part 1
Self-administered

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)

	None	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**

TECH24

Sleep Questionnaire Part 2
Self-administered

During the past month...	
when have you usually gone to bed at night?	|__|__|:|__|__| |__| |__| hours : min AM PM
how long has it usually taken you to fall asleep each night?	|__|__|:|__|__| hours : min
when have you usually gotten up in the morning?	|__|__|:|__|__| |__| |__| hours : min AM PM
how much *actual sleep* did you get at night?	|__|__|:|__|__| hours : min

When you experience the following situations, how likely is it for you to have difficulty sleeping?
Circle an answer even if you have not experienced these situations recently.

	Not likely	Somewhat likely	Moderately likely	Very likely
Before an important meeting the next day	**0**	**1**	**2**	**3**
After a stressful experience during the day	**0**	**1**	**2**	**3**
After a stressful experience in the evening	**0**	**1**	**2**	**3**
After getting bad news during the day	**0**	**1**	**2**	**3**
After watching a frightening movie or TV show	**0**	**1**	**2**	**3**
After having a bad day at work	**0**	**1**	**2**	**3**
After an argument	**0**	**1**	**2**	**3**
Before having to speak in public	**0**	**1**	**2**	**3**
Before going on vacation the next day	**0**	**1**	**2**	**3**

|__|	**On average over the past year, how often do you snore?**	0= Never 1= Less than 1 night per week 2= 1-2 nights per week 3= 3-5 nights per week 4= 6-7 nights per week 9= Don't know
|__|	**On average over the past year, how often do you have times when you stop breathing while you are asleep?**	

TECH25

Sleep Questionnaire Part 3
Self-administered

One hears about "morning" and "evening" types of people. Which ONE of these types do you consider yourself to be? Please **check ONE box** below

☐ 1	**Definitely a "morning" type**
☐ 2	**Rather more a "morning" than an "evening" type**
☐ 3	**Neither a "morning" nor an "evening" type**
☐ 4	**Rather more an "evening" than a "morning" type**
☐ 5	**Definitely an "evening" type**

|__|__| hour |__|__| min ☐ AM ☐ PM	**Considering only your "feeling best" rhythm, <u>at what time would you get up</u> if you were entirely free to plan your day?**
|__|__| hour |__|__| min ☐ AM ☐ PM	**Considering only your "feeling best" rhythm, <u>at what time would you go to bed</u> if you were entirely free to plan your evening?**

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**
if yes, fill☞ Do you wear a mask ("CPAP") or other device at night to treat sleep apnea?	**0**	**1**	**9**
Insomnia	**0**	**1**	**9**
Restless legs	**0**	**1**	**9**

TECH26

Framingham Study Vascular Function Participant Worksheet

(circle on)e			**Keyer 1:** _____	**Keyer 2:** _____
0	**1**	**9**	**Have you had any caffeinated drinks in the last 6 hours?** (0=No, 1=Yes, 9=Unk.)	
		if yes fill ☞	|__|__| **How many cups?** (99=Unk.)	
0	**1**	**9**	**Have you eaten anything else including a fat free cereal bar this morning?** (0=No, 1=Yes, 9=Unknown)	
0	**1**	**9**	**Have you smoked cigarettes in the last 6 hours?** (0=No, 1=Yes, 9=Unk.)	
		if yes fill ☞	|__|__|:|__|__| **If yes, how many hours and minutes since your last cigarette?** (99:99=Unk.)	

Tonometry

|__|__|/|__|__|/|__|__|__|__|	**Date of Tonometry scan?** (99/99/9999=Unk.)
|__|__|__|	**Tonometry Sonographer ID**
|__|__|__|-|__|__|__|	**Tonometry CD number**
0 **1**	**Was Tonometry done?** 0= No, test was not attempted or done 1= Yes, test was done, even if all 4 pulses could not be acquired and recorded.
If no fill ☞	**Reason why: (***Check all that apply)*
	☐ Subject refusal
	☐ Subject discomfort
	☐ Time constraint
	☐ Equipment problem, specify _____
	☐ Other, specify _____

Not for Data Entry.

Distances:
_____Carotid(mm) _____Brachial(mm) _____Radial(mm) _____Femoral(mm)

Date of exam

_____/_____/_____

Framingham Heart Study

Summary Sheet to Personal Physician

Blood Pressure	First Reading	Second Reading
Systolic		
Diastolic		

ECG Diagnosis _____

_____

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

Summary of Findings_____

☐ 1. **No history or physical exam findings to suggest cardiovascular disease**
(check box if applicable)

_____

_____

_____

_____

_____

_____

_____

_____
Examining Physician

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

Referral Tracking

☐ Check here if whole page is blank. Reason why_____

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

RESULT	Reason for further evaluation: *(Check ALL that apply)*.	
☐	**Blood Pressure** **result** _____/_____ mmHg **result** _____/_____ mmHg	SBP or DBP Phone call ≥ 200 or ≥110 Expedite ≥ 180 or ≥100 Elevated ≥ 140 or ≥90
	Write in abnormality	
☐	**Abnormal laboratory result**_____	
☐	**ECG abnormality** _____	
☐	**Clinic Physician** *identified medical problem*_____	
☐	**Other** _____	

Method used to inform participant of need for further medical evaluation *(Check ALL that apply)*	
☐	**Face-to-face in clinic**
☐	**Phone call**
☐	**Result letter**
☐	**Other**

Method used to inform participant's personal physician of need for further medical evaluation *(check ALL that apply)*	
☐	**Phone call**
☐	**Result letter mailed**
☐	**Result letter FAX'd** *(inform staff if Fax needed)*
☐	**Other**

Date referral made: _____/____/_____

ID number of person completing the referral: _____

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

Medical History—Hospitalizations, ER Visits, MD Visits

DATE _____

DATE of last exam *«Lexam»*

DATE of last medical history update *«Lupdate»*

Health Care	
Since your last exam or medical history update	
|__|__|__|	**1st Examiner ID** _____ 1st Examiner Name
| 0 |	**1st Examiner Prefix** (0=MD, 1=Tech. for OFFSITE visit)
|__|	**Hospitalizations** (*not just E.R.*) (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unk.)
|__|	**E.R. Visits** (0=No, 1=Yes, 1 visit, 2=Yes, more than 1 visit, 9=Unk.)
|__|	**Day Surgery** (0=No, 1=Yes, 9=Unk.)
|__|	**Major illness with visit to doctor** (0=No, 1=Yes, 1 visit, 2=Yes, more than 1 visit; 9=Unk.)
|__|	**Check up by doctor or other health care provider?** (0=No, 1=Yes, 9=Unk.)
|__|	**Have you had a fever or infection in <u>past two weeks</u>?** (0=No, 1=Yes, 9=Unk.)
|__|__| |__|__| |__|__|__|__| 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)	Name & Address of Hospital or Office	Doctor

MD01

Medical History—Medications

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

Since your last exam

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

|__| **Have you been told by doctor you have high blood pressure or hypertension?**
|__| **Have you taken medication for high blood pressure or hypertension?**
|__| **Have you been told by doctor you have high blood cholesterol or high triglycerides?**
|__| **Have you taken medication for high blood cholesterol or high triglycerides?**
|__| **Have you been told by doctor you have high blood sugar or diabetes?**
|__| **Have you taken medication for high blood sugar or diabetes?**
|__| **Have you taken medication for cardiovascular disease? (for example angina/chest pain, heart failure, atrial fibrillation/heart rhythm abnormality, stroke, leg pain when walking, peripheral artery disease)**

MD02

Medical History – Prescription and Non-Prescription Medications

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

|__| **Medication bag with medications or bottles/packs brought to exam?** (0=No 1=Yes)

*****List medications taken regularly in past month/ongoing medications*****
Code ASPIRIN ONLY on screen MD02.

☐ **Check if NO medication taken**

Medication Name (Print first 20 letters)	**Strength** (include mg, IU, etc)	**Route** 1= oral, 2=topical, 3=injection, 4=inhaled, 5=drops,6=nasal 88=other	**Number per** (circle one) #	**Number per** (circle one) day/week/month/year 1 / 2 / 3 / 4	**PRN** 0=no, 1=yes,9=Unk.	**Check if OTC med**
EXAMPLE: S A M P L E D R U G N A M E	100 mg	1	1	D W M Y	0	☐
				D W M Y		☐
				D W M Y		☐
				D W M Y		☐
				D W M Y		☐
				D W M Y		☐
				D W M Y		☐
				D W M Y		☐
				D W M Y		☐
				D W M Y		☐
				D W M Y		☐

Continue on the next page ⇢

MD03

Medical History – Prescription and Non-Prescription Medications

Medication Name (Print first 20 letters)	Strength (include mg, IU, etc)		Route 1= oral, 2=topical, 3=injection, 4=inhaled, 5=drops,6=nasal 88=other	Number per (circle one) #	Number per (circle one) day/week/month/year 1 / 2 / 3 / 4	PRN 0=no, 1=yes, 9-Unk	Check if OTC med.
EXAMPLE: SAMPLE DRUG NAME	100	mg	1	1	D W M Y	0	☐
					D W M Y		☐
					D W M Y		☐
					D W M Y		☐
					D W M Y		☐
					D W M Y		☐
					D W M Y		☐
					D W M Y		☐
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					D W M Y		☐
					D W M Y		☐
					D W M Y		☐
					D W M Y		☐
					D W M Y		☐
					D W M Y		☐

MD04

Medical History–Female Reproductive History Part 1

☐ **Check here if Male Participant (and skip to Smoking Questions page 48/MD08)**

«Meno» **Check here if definitely menopausal (and skip to Female History Part 3 page 47) (*preloaded from previous exam)***

|__| **Since your last exam have you taken or used birth control pills, shots, or hormone implants for birth control or medical indications (not post menopausal hormone replacement)?** (0=no, 1=yes, now, 2=yes, not now, 9=Unk.)

|__| **Have you been pregnant since last exam?** (0=No, 1=Yes, 9=Unk.)

If yes, fill☞

|__|__|	**Number of pregnancies?**	fill in number
|__|__|	**Number of live births?**	
|__|	**During any of these pregnancies, were you told you had high blood pressure or hypertension?**	0=No 1=Yes 9=Unk.
|__|	**During any of these pregnancies, were you told you had eclampsia, pre-eclampsia (toxemia)?**	
|__|	**During any of these pregnancies, were you told you had high blood sugar or diabetes?**	

MD05

Medical History–Female Reproductive History Part 2

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

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

|__|__|*|__|__|*|__|__|__|__| month day year	**When was the first day of your last menstrual period?** 99/99/9999=Unk. **88/88/8888**= periods stopped for more than 1 year or using postmenopausal hormones *If periods stopped due to pregnancy, breastfeeding, hormonal contraception or health condition code date of last menstrual period*
|__|__|	**Age when periods stopped** (00=not stopped, 99=Unk.) *If periods now induced by hormones, code age when periods naturally stopped.* *If periods stopped due to pregnancy, breastfeeding, or hormonal contraception code as 0=not stopped*
|__|	**Was your menopause natural or the result of surgery, chemotherapy, or radiation?** (0=still menstruating, 1=natural, 2=surgical, 3=chemo/radiation, 4=other, 9=Unk.) *If periods stopped due to pregnancy, breast feeding, or hormonal contraception code as 0=still menstruating*

MD06

Medical History–Female Reproductive History Part 3

Surgery History

|__| **Since your last exam have you had a hysterectomy (uterus/womb removed)?** (0=No, 1=Yes, 9=Unk.)

If yes, fill☞

|__|__| **Age at hysterectomy?** 99=Unk.

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

|__| **Since last exam have you had an operation to remove one or both of your ovaries?** (0=No, 1=Yes, 9=Unk.)

If yes, fill☞

|__|__| **Age when ovaries removed?** *If more than one surgery, use age <u>at last surgery</u>* 99=Unk.

Number of ovaries removed? (check one)

☐	☐	☐	☐
1=one ovary	2=two ovaries	3= unknown number of ovaries	4= part of an ovary

|__| **Have you since your last exam taken hormone replacement therapy (estrogen/progesterone) or a selective estrogen receptor modulator (such as evista or raloxifene)?** (0=No, 1=Yes, now, 2=Yes, not now, 9=Unk.)

Comments_____

_____

_____

_____

_____

MD07

Medical History--Smoking

Cigarettes

|__| **Since your last exam have you smoked cigarettes regularly?** (0=No, 1=Yes, 9=Unk.)

If yes, fill☞

|__| **Have you smoked cigarettes regularly in the last year?** *(No means less than 1 cigarette a day for 1 year.)* (0=No, 1=Yes, 9=Unk.)

|__| **Do you now smoke cigarettes (as of 1 month ago)?** (0=No, 1=Yes, 9=Unk.)

|__|__| **How many cigarettes do you smoke per day now?** (99=Unk.)

Questions below refer to "since your last exam"

|__|__| **During the time you were smoking, on average how many cigarettes per day did you smoke** (99=Unk.)

|__|__| **If you have stopped smoking cigarettes completely, how old were you when you stopped?** (Age stopped, 00=Not stopped, 99=Unk.)

|__| **When you were smoking, did you ever stop smoking for >6 months?** (0=No, 1=Yes, 9=Unk.)

If yes, fill☞ |__|__| **For how many years in total did you stop smoking cigarettes** (01=6 months – 1 year, 99=Unk.)

Pipes or Cigars

|__| **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=Unk.

Comments:_____

_____

_____

MD08

Medical History –Alcohol Consumption

Now I will ask you questions regarding your alcohol use.

Do you drink any of the following beverages at least once a month? (0=No, 1=Yes, 9=Unk.)	
|__|	Beer
|__|	Wine
|__|	Liquor/spirits

If yes, what is your average number of servings in a typical week or month over past year? (999=Unk.)

Code alcohol intake as EITHER weekly OR monthly as appropriate.

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

|__|__|__| **At what age did you stop drinking alcohol?** (0= Not stopped, 888=Never drank, 999=Unk.)

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

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

Comments:_____

_____

_____

MD09

Medical History—Respiratory Symptoms Part I

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

	__	**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?**	
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?**	
	|__|__| **How many years have you had this cough?** *(# of years)*	1=1 year or less 99=Unk.

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

	__	**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?**	
If **YES** to **either** question above **answer** the following:			
	|__| **Do you bring up phlegm from your chest on most days for three consecutive months or more during the year?**	
	|__|__| **How many years have you had trouble with phlegm?** *(# of years)*	1=1 year or less 99=Unk.

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

In the past 12 months…

	__	**Have you had wheezing or whistling in your chest at any time?**	
if yes, fill all ☞	|__| **How often have you had this wheezing or whistling?** 0=Not at all 1=MOST days or nights 2=A few days or nights a WEEK 3=A few days or nights a MONTH 4=A few days or nights a YEAR 9=Unk.	
	|__| **Have you had this wheezing or whistling in the chest when you had a cold?**	
	|__| **Have you had this wheezing or whistling in the chest apart from colds?**	
	|__| **Have you had an attack of wheezing or whistling in the chest that had made you feel short of breath?**	

MD10

Medical History—Respiratory Symptoms Part II

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

In the past 12 months…

|__| **Have you been awakened by shortness of breath?**

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

|__| **Have you been awakened by coughing?**

if yes, fill all☞

|__| **How often have you been awakened by coughing?**
0=Not at all 1=MOST days or nights 2=A few days or nights a WEEK
3=A few days or nights a MONTH 4=A few days or nights a YEAR 9=Unk.

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

Since your last exam…

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

if yes, fill all☞

|__| **Do you have to walk slower than people of your age on level ground because of shortness of breath?**

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

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

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

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

|__| **Have you been told by your doctor you had heart failure or congestive heart failure?**

if yes, fill☞

Name of doctor _____

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

|__| **Have you been hospitalized for heart failure?** *(Provide details on MD01-Health Care page 47)*

CHF First Examiner Opinion

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

Comments_____

_____

_____

MD11

Physical Exam—Blood Pressure

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

Comments for Protocol modification_____

_____

_____

_____

MD12

Medical History—Chest pain

|__|	**Since your last exam have you experienced any chest discomfort?** *(please provide narrative comments in addition to completing the appropriate boxes)*	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill ☞ and below	|__|	**Chest discomfort with exertion or excitement**	
	|__|	**Chest discomfort when quiet or resting**	

Chest Discomfort Characteristics

|__|__|*|__|__|__|__|	**Date of onset** *(mo/yr)*	99/9999=Unk.
|__|__|__|	**Usual duration** *(minutes)*	1=1 min or less, 900=15 hrs or more, 999=Unk.
|__|__|__|	**Longest duration** *(minutes)*	1=1 min or less, 900=15 hrs or more, 999=Unk.
|__|	**Location**	0=No, 1=Central sternum and upper chest, 2=L Up Quadrant, 3=L Lower ribcage, 4=R Chest, 5=Other, 6=Combination, 9=Unk.
|__|	**Radiation**	0=No, 1=Left shoulder or L arm, 2=Neck, 3=R shoulder or arm, 4=Back, 5=Abdomen, 6=Other, 7=Combination, 9=Unk.
|__|__|__|	**Number of episodes of chest pain in past month**	999=Unk.
|__|__|__|	**Number of episodes of chest pain in past year.**	999=Unk.
|__|	**Type**	1=Pressure, heavy, vise, 2=Sharp, 3=Dull, 4=Other, 9=Unk.
|__|	**Relief by Nitroglycerin 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=Unk.

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

CHD First Examiner Opinions

|__|	**Angina pectoris**	0=No, 1=Yes, 2=Maybe, 8=No revasculation 9=Unk.
if yes,fill ☞ |__|	**Angina pectoris since revascularization procedure**	
|__|	**Coronary insufficiency**	
|__|	**Myocardial infarct**	

Comments_____

_____

_____

Medical History—Atrial Fibrillation/Syncope

Since your last exam or medical history update…

|__|	**Have you been told you have/had atrial fibrillation?**	0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes,fill☞	|__|__|*|__|__|*|__|__|__|__| **Date of first episode**	99/99/9999=Unk.
	|__| **ER/hospitalized or saw M.D.**	0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unk.
if yes, fill☞	_____ **Name of the Hospital** (write Unk. if unknown)	
	_____ **Name of M.D.** (write Unk. if unknown)	

\|__\| **Do you have a family history of a heart rhythm problem called atrial fibrillation?** 0=No, 1=Yes, 9=Unk

if yes,fill☞	**Mother**	**Father**	**Siblings**	**Children**	0=No, 1=Yes, 9=Unk.
	|__|	|__|	|__|	|__|	

|__|	**Have you fainted or lost consciousness?** *(If event immediately preceded by head injury or accident code 0=No)*		0=No, 1=Yes, 2=Maybe, 9=Unk..
if yes, fill all☞	|__|__|__|	**Number of episodes in the past two years**	999=Unk.
	|__|__|*|__|__|__|__|	**Date of first episode** *(mo/yr)*	99/9999=Unk.
	|__|__|__|	**Usual duration of loss of consciousness** *(minutes)*	999=Unk.,1=1 min or less
	|__|	**Did you have any injury caused by the event?**	0=No, 1=Yes, 2=Maybe, 9=Unk.
	|__|	**ER/hospitalized or saw M.D.**	0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unk.
if yes, fill☞	_____ **Name of the Hospital** (write Unk.. if unknown)		
	_____ **Name of M.D.** (write Unk. if unknown)		

|__|	**Have you had a head injury with loss of consciousness?**		0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes, fill☞	|__|__| * |__|__| * |__|__|__|__|	**Date of serious head injury with loss of consciousness**	99/99/9999=Unk.
|__|	**Have you had a seizure**?		0=No, 1=Yes, 2=Maybe, 9=Unk.
if yes,fill☞	|__|__| * |__|__| * |__|__|__|__|	**Date of most recent seizure**	99/99/9999=Unk.
	|__|	**Are you being treated for a seizure disorder?**	0=No, 1=Yes, 2=Maybe, 9=Unk.

Syncope First Examiner Opinion

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

if yes, fill☞			
	|__|	**Cardiac syncope**	0=No, 1=Yes, 2=Maybe, 9=Unk.
	|__|	**Vasovagal syncope**	
	|__|	**Other-Specify:** _____	

Comments:_____

_____**MD14**

Medical History—Cerebrovascular Diseases

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

|__|	**Sudden muscular weakness**	0=No,
|__|	**Sudden speech difficulty**	
|__|	**Sudden visual defect**	1=Yes,
|__|	**Sudden double vision**	
|__|	**Sudden loss of vision in one eye**	2=Maybe,
|__|	**Sudden numbness, tingling**	9=Unk.
if yes, fill ☞	|__| **Numbness and tingling is positional**	
|__|	**Head CT scan *OTHER THAN FOR THE FHS***	0=No,1=Yes, 2= Maybe,9=Unk.
if yes, fill ☞	|__|__| * |__|__| * |__|__|__|__| **Date**	99/99/9999=Unk.
	_____ **Place**	
|__|	**Head MRI scan *OTHER THAN FOR THE FHS***	0=No,1=Yes, 2= Maybe,9=Unk.
if yes, fill ☞	|__|__| * |__|__| * |__|__|__|__| **Date**	99/99/9999=Unk.
	_____ **Place**	
|__|	**Seen by neurologist** *(write in who and when below)* _____	
|__|	**Have you been told by a doctor you had a stroke or TIA** (transient ischemic attack, mini-stroke)**?**	0=No,
|__|	**Have you been told by a doctor you have Parkinson Disease?**	1=Yes,
|__|	**Have you been told by a doctor you have memory problems, dementia or Alzheimer's disease?**	2=Maybe,
|__|	**Do you feel or do other people think that you have memory problems that prevent you from doing things you've done in the past?**	9=Unk.
|__|	**Do you feel like your memory is becoming worse?**	

Cerebrovascular Disease First Examiner Opinion

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

Comments_____

Medical History--Venous and Peripheral Arterial Disease

Venous Disease

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

|__|	**Deep Vein Thrombosis - DVT** (blood clots in legs or arms)	0=No,1=Yes, 2=Maybe, 9=Unk.
|__|	**Pulmonary Embolus – PE** (blood clot in lungs)	

Peripheral Arterial Disease

Since your last exam have you had…

\|__\| **Do you get discomfort in either leg on walking?** (0=No, 1=Yes, 9=Unk.)

if yes, fill ☞

\|__\| **Does this discomfort ever begin when you are standing still or sitting?** (0=no, 1=yes, 9=Unk.)

\|__\|__\| **When walking at an ordinary pace on level ground, how many city blocks until symptoms develop** (1=1 block or less, 99=Unk.) *where 10 blocks=1 mile, code as no if more than 98 blocks required to develop symptoms*

Left	Right	Claudication symptoms	0=No, 1=Yes, 9=Unk.
|__|	|__|	**Discomfort in calf while walking**	
|__|	|__|	**Discomfort in lower extremity (not calf) while walking** **Write in site of discomfort**_____	
	|__|	**Occurs with first steps (code worse leg)**	
	|__|	**Do you get the discomfort when you walk up hill or hurry?**	
	|__|	**Does the discomfort ever disappear while you are still walking?**	
	|__|	**What do you do if you get discomfort when you are walking?** (1=stop, 2=slow down, 3=continue at same pace, 9=Ukn.)	
	|__|__|__|	**Time for discomfort to be relieved by stopping (minutes)** (000=No relief with stopping, 999=Unk.)	
	|__|__|	**Number of days/month of lower limb discomfort** (1=1 day/month or less, 99=Unk.)	

\|__\| **Since your last exam have you been told by a doctor you have intermittent claudication or peripheral artery disease?** (0=No, 1=Yes, 9=Unk.)

if yes, fill ☞

Name of doctor _____

Date of visit \|__\|__\|*\|__\|__\|*\|__\|__\|__\|__\| 99/99/9999=Unk.

\|__\| **Since your last exam have you been told by a doctor you have spinal stenosis?** (0=No, 1=Yes, 9=Unk.)

Intermittent Claudication First Examiner Opinion

\|__\| **Intermittent Claudication** 0=No, 1=Yes, 2=Maybe, 9=Unk.

Comments

_____

_____

MD16

Medical History-- CVD Procedures

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

0=No, 1=Yes 2=Maybe, 9=Unk.	Cardiovascular Procedures *(if procedure was repeated code only first and provide narrative)*
|__|	**Heart Valvular Surgery**
if yes fill☞	|__|__|__|__| Year done (9999=Unk.)
|__|	**Exercise Tolerance Test**
if yes fill☞	|__|__|__|__| Year done (9999=Unk.)
|__|	**Coronary arteriogram**
if yes fill ☞	|__|__|__|__| Year done (9999=Unk.)
|__|	**Coronary artery angioplasty or stent**
if yes fill☞	|__|__|__|__| Year done (9999=Unk.)
|__|	**Coronary bypass surgery**
if yes fill☞	|__|__|__|__| Year done (9999=Unk.)
|__|	**Permanent pacemaker insertion**
if yes fill ☞	|__|__|__|__| Year done (9999=Unk.)
|__|	**AICD**
if yes fill ☞	|__|__|__|__| Year done (9999=Unk.)
|__|	**Carotid artery surgery or stent**
if yes fill ☞	|__|__|__|__| Year done (9999=Unk.)
|__|	**Thoracic aorta surgery**
if yes fill ☞	|__|__|__|__| Year done (9999=Unk.)
|__|	**Abdominal aorta surgery**
if yes fill ☞	|__|__|__|__| Year done (9999=Unk.)
|__|	**Femoral or lower extremity surgery**
if yes fill ☞	|__|__|__|__| Year done (9999=Unk.)
|__|	**Lower extremity amputation**
if yes fill ☞	|__|__|__|__| Year done (9999=Unk.)
|__|	**Other Cardiovascular Procedure (write in below)**
if yes fill ☞	|__|__|__|__| Year done (9999=Unk.) Description_____

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

Comments:_____

MD17

Physical Exam—Blood Pressure

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

Comments for Protocol modification_____

_____

_____

_____

_____

History of Kidney Disease		
|__|	**Have you had a kidney stone in the past 10 years?** (0=No, 1=Yes, 9=Unk.)	
if yes, fill☞ |__|	**ER/hospitalized or saw M.D.** **(**0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unk.)	
if yes, fill☞	_____	**Name of the Hospital** (write Unk.. if unknown)
	_____	**Name of M.D.** (write Unk. if unknown)

MD18

Cancer Site or Type

|__| **Since your last exam or medical history update have you had a cancer or a tumor?**
(0=No and skip to next page MD20; If 1=Yes, 2=Maybe, 9=Unk. please continue)

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

|__| **Diagnostic biopsy done**? (0=No, 1=Yes, 9=Unk.)

if yes fill ☞ ___ - ___ -_____ **Date** **Location of biopsy**_____

Hosp./office name_____ **Address (city/state)**_____

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

_____

_____

MD19

Physical Exam—Respiratory, Heart, Abdomen

OFFSITE VISIT – leave page BLANK

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

Heart		
|__|	**S3 Gallop**	0=No, 1=Yes, 2=Maybe, 9=Unk.
|__|	**S4 Gallop**	
|__|	**Systolic Click**	
|__|	**Neck vein distention at 90 degrees** (sitting upright)	

|__| if yes, fill below	**Systolic murmur(s)**			0=No, 1=Yes, 2=Maybe, 9=Unk.
Murmur Location	**Grade** 0=No sound 1 to 6 for grade of sound heard 9=Unk.	**Type** 0=None 1=Ejection 2=Regurgitant 3=Other 9=Unk.	**Radiation** 0=None 1=Axilla 2=Neck 3=Back 4=Rt. chest 9=Unk.	**Origin** 0=None, indet. 1=Mitral 2=Aortic 3=Tricuspid 4=Pulm 9=Ukn.
Apex	|__|	|__|	|__|	|__|
Left Sternum	|__|	|__|	|__|	|__|
Base	|__|	|__|	|__|	|__|

|__| if yes, fill ☞	**Diastolic murmur(s)**	0=No, 1=Yes, 2=Maybe, 9=Unk.
	|__| **Valve of origin for diastolic murmur(s)** (1=Mitral, 2=Aortic, 3=Both, 4=Other, 8=N/A, 9=Unk)	

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

Comments _____

_____

_____

Physical Exam--Peripheral Vessels—Veins and Arterial pulses

OFFSITE VISIT – leave page BLANK

Left	Right	Lower Extremity Abnormalities
|__|	|__|	**Stem varicose veins** *(Do not code reticular or spider varicosities)* (0=No abnormality 1=Yes 9=Unk.)
|__|	|__|	**Ankle edema** (0=No, 1=Yes, 2=Maybe, 8=absent due to amputation 9=Unk.)
|__|	|__|	**Amputation level** (0=No, 1=Toes only, 2=Foot, 3=below Knee, 4=above Knee, 5= Other, write in_____, 9=Unk.)

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

Comments_____

_____

_____

MD21

Physical Exam--Neurological Exam

OFFSITE VISIT – leave page BLANK

Neurological Exam			
Left	**Right**		
|__|	|__|	**Carotid Bruit**	0=No, 1=Yes, 2=Maybe, 9=Unk.
	|__|	**Speech disturbance**	
	|__|	**Disturbance in gait**	
	|__|	**Other neurological abnormalities on exam** Specify_____	

Comments _____

_____

_____

_____

MD22

Electrocardiograph--Part I

OFFSITE ONLY		
|__|__|__|	**MD Id#**	_____ **MD Name**

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

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

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

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

MD23

Electrocardiograph-Part II

Myocardial Infarction Location		
|__|	**Anterior**	0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.
|__|	**Inferior**	
|__|	**True Posterior**	

Left Ventricular Hypertrophy Criteria		
|__|	**R > 20mm in any limb lead**	0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk.
|__|	**R > 11mm in AVL**	
|__|	**R in lead I plus S in lead III ≥ 25mm**	
	Measured Voltage	
*|__|__|	**R AVL in mm** (at 1 mv = 10 mm standard) **Be sure to code these voltages**	
*|__|__|	**S V3 in mm** (at 1 mv = 10 mm standard) **Be sure to code these voltages**	
	R in V5 or V6-----S in V1 or V2	
|__|	**R≥ 25mm**	0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk.
|__|	**S≥ 25mm**	
|__|	**R or S ≥ 30mm**	
|__|	**R + S ≥ 35mm**	
|__|	**Intrinsicoid deflection ≥.05 sec**	
|__|	**S-T depression (strain pattern)**	

Hypertrophy, enlargement, and other ECG Diagnoses	
|__|	**Nonspecific S-T segment abnormality** (0=No, 1=S-T depression, 2=S-T flattening, 3=Other, 9=Fully paced or Unk.)
|__|	**Nonspecific T-wave abnormality** (0=No, 1=T inversion, 2=T flattening, 3=Other, 9=Fully paced or Unk.)
|__|	**U-wave present** (0=No, 1=Yes, 2=Maybe, 9=Paced or Unk.)
|__|	**Atrial enlargement** (0=None, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unk.**)**
|__|	**RVH** (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unk.; **If complete RBBB OR LBBB present, RVH=9**)
|__|	**LVH** (0=No, 1=LVH with strain, 2=LVH with mild S-T Segment Abn, 3=LVH by voltage only, 9=Fully paced or Unk., **If complete LBBB present, LVH=9)**

Comments_____

_____

_____

MD24

Clinical Diagnostic Impression--Part I

Heart Diagnoses		
|__|	**Rheumatic Heart Disease**	0=No, 1=Yes, 2=Maybe, 9=Unk.
|__|	**Aortic Valve Disease**	
|__|	**Mitral Valve Disease**	
|__|	**Arrhythmia**	
|__|	**Other Heart Disease (includes congenital)**	
	(Specify)_____	

Peripheral Vascular Disease		
|__|	**Other Peripheral Vascular Disease**	0=No, 1=Yes, 2=Maybe, 9=Unk.
|__|	**Other Vascular Diagnosis**	
	(Specify)_____	

Neurological Disease		
|__|	**Stroke/ TIA**	0=No, 1=Yes, 2=Maybe, 9=Unk.
|__|	**Dementia**	
|__|	**Parkinson's Disease**	
|__|	**Adult Seizure Disorder**	
|__|	**Migraine**	
|__|	**Other Neurological Disease**	
	(Specify)_____	

Comments _____

_____

_____

_____

MD25

Clinical Diagnostic Impression--Part II. Non Cardiovascular Diagnoses

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

Comments

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Second Examiner Opinions

OFFSITE VISIT – leave page BLANK

|__|__|__| **2nd Examiner ID number** _____ **2nd Examiner Last Name**

Coronary Heart Disease

(Provide initiators, qualities, radiation, severity, timing, presence after procedures done)

Item requires 2nd opinion *Check ALL that apply.*	2nd opinion		
☐	|__|	**Congestive Heart Failure**	0=No, 1=Yes, 2=Maybe, 9=Unk.
☐	|__|	**Cardiac Syncope**	
☐	|__|	**Angina Pectoris**	
☐	|__|	**Coronary Insufficiency**	
☐	|__|	**Myocardial Infarct**	

Comments about heart disease _____

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Intermittent Claudication

(Provide initiators, qualities, radiation, severity, timing, presence after procedures done)

Item requires 2nd opinion *Check ALL that apply.*	2nd opinion		
☐	|__|	**Intermittent Claudication**	0=No, 1=Yes, 2=Maybe, 9=Unk.

Comments about peripheral artery disease _____

_____

Cerebrovascular Disease

(Provide initiators, qualities, severity, timing, presence after procedures done)

Item requires 2nd opinion *Check ALL that apply.*	2nd opinion		
☐	|__|	**Stroke**	0=No, 1=Yes, 2=Maybe, 9=Unk.
☐	|__|	**TIA**	

Comments about possible cerebrovascular disease_____

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Any Additional Comments for Second Examiner Opinions.