

# Framingham Heart Study

Generation 3, NOS, Omni 2

## EXAM 3

### Research Center Questionnaire

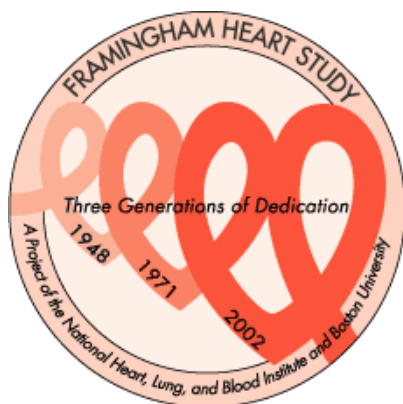
SECTIONS:

Admit	(pages 1 – 6) plus consents
MD	(pages 7 – 112)
Self-Administered Questions	(pages 113 – 142)
Tech	(pages 143 – 174)
Tonometry	(pages 175 – 177)

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## Admit Section





# Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

## Participant Information

Date of this FHS exam (today's date)

\* must provide value



Today

M-D-Y

Site

\* must provide value

- ☐ Heart Study
- ☐ Nursing home
- ☐ Residence
- ☐ Other

First name

Last name

Date of Birth






Today

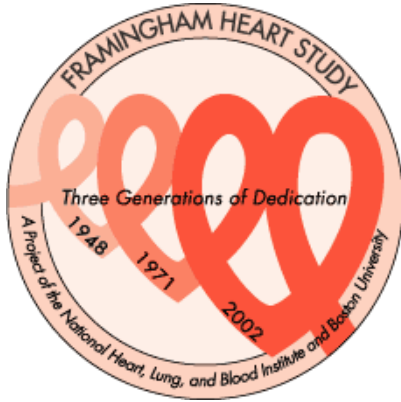
M-D-Y

## Additional Comments

### Participant Information

## Imported Validated Data for Data Management Use

Year of birth	<input type="text"/>	<a href="#">View equation</a>
Year of this FHS exam	<input type="text"/>	<a href="#">View equation</a>
Age (in years)	<input type="text"/>	<a href="#">View equation</a>
IDTYPE	<p><input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 72</p> <p>2 = NOS, 3 = Gen 3, 72 = Omni Gen 2</p>	
ID	<input type="text"/> FHS ID (4-digit)	
Sex	<p><input type="radio"/> Male <input type="radio"/> Female</p>	
Date of last exam	<input type="text"/> 	<input type="button" value="Today"/> M-D-Y
Year of last exam	<input type="text"/>	<a href="#">View equation</a>
Date of last medical health update	<input type="text"/> 	<input type="button" value="Today"/> M-D-Y
Date of last medical information	<input type="text"/> 	<input type="button" value="Today"/> M-D-Y



# Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

## A02 - Research Proxy

<b>I, living at:</b>	<input type="text"/>
<b>appoint the following person(s) to make decisions about my participation in the Framingham Heart Study ("Research Proxy"):</b>	
<b>Research Proxy Name:</b>	<input type="text"/>
<b>Relation:</b>	<input type="text"/>
<b>Address:</b>	<input type="text"/>
	<input type="text"/>
<b>City State Zip:</b>	<input type="text"/>
<b>Home Phone:</b>	<input type="text"/>
<b>Work Phone:</b>	<input type="text"/>
<b>Other Phone:</b>	<input type="text"/>

**Alternate: If Research Proxy cannot serve or continue to serve, I name this person (Optional):**

<b>Alternate Proxy Name:</b>	<input type="text"/>
<b>Relation:</b>	<input type="text"/>
<b>Address:</b>	<input type="text"/>
	<input type="text"/>
<b>City State Zip:</b>	<input type="text"/>
<b>Home Phone:</b>	<input type="text"/>
<b>Work Phone:</b>	<input type="text"/>
<b>Other Phone:</b>	<input type="text"/>

**Effective Date and Termination**

**This durable power of attorney shall take effect when signed by me and shall not be affected by lapse in time or by my subsequent disability or incapacity which makes me unable to make decisions about participation in research.**

**Powers of Research Proxy**

**My Research Proxy shall have the authority to make all research participation decisions for me, including decisions about whether or not to enroll me or continue my participation in a research study [both minimal and greater than minimal risk research procedures as determined by the federal regulations and in consultation with the IRB]. My Research Proxy is to have the same authority to make research participation decisions as I would have. S/he has the authority to provide medical information and to consent for testing and examinations,. S/he further has the power to authorize the provision of records related to payment, treatment or services to me or on my behalf from any hospital, physician, or medical source to the Framingham Heart Study.**

**I, the undersigned Principal, by signing my name to this declare that I understand its contents and that I sign it willingly.**

**Principal:**  [Add signature](#)

**Principal Date:**    M-D-Y

**[Complete the following if the Principal is physically incapable of signing:]**

**I hereby sign the name of the Principal at the Principal's direction and in the presence of the Principal and two witnesses.**

**Name of Signer:**

**Signer Date:**    M-D-Y

**Address of Signer:**

**Witness Signature:**  [Add signature](#)

Witness Date:	<input type="text"/>		<input type="button" value="Today"/>	M-D-Y
Witness (2) Signature:	 <a href="#">Add signature</a>			
Witness (2) Date:	<input type="text"/>		<input type="button" value="Today"/>	M-D-Y





Framingham Heart Study  
Group 3 Exam 3  
RESEARCH CONSENT FORM

## ***Welcome Back to the Framingham Heart Study***

*Together we are helping to fight heart disease and other major diseases and health conditions through research.*

### ***Why is the research study being done?***

The Framingham Heart Study is a long term research study. The purpose of the study is:

- (1) To help understand how heart and blood vessel diseases, lung and blood diseases, stroke, memory loss, cancer, and other major diseases and health conditions develop; and
- (2) To examine DNA and its relationship to the risks of developing these diseases and other health conditions.

**The research examination that will be conducted as part of this study is not clinical care. The tests are for research purposes only. We do not provide medical services. This research examination does not take the place of medical care by your own health care provider.**

### ***About your consent***

Please read this research consent form carefully. It tells you important information about the research study. Taking part in a research study is voluntary. The decision whether or not to take part in all or any part of the research exam is entirely up to you. If you choose to take part, you can decide to stop at any time. Your decision will be honored and respected. There will be no penalty to you if you decide to stop or not to take part.

### ***If I have questions or concerns about this research study, whom can I call?***

If you have any questions about the research or about this form, please ask us. You can call us with your questions or concerns. You can ask questions as often as you want.

You can call a study staff member directly at (508) 872-6562, or you can send an email to [FHS@bu.edu](mailto:FHS@bu.edu).

The Framingham Heart Study is led by investigators from Boston University and the National, Heart, Lung, and Blood Institute at the National Institutes of Health. Dr. Vasan S Ramachandran and Dr. Daniel Levy are in charge of the research study. You can contact Dr. Ramachandran at (617) 638-8090 Monday to Friday between 9am and 5pm or by email at [vasan@bu.edu](mailto:vasan@bu.edu) and Dr. Levy at (508) 935-3400 Monday to Friday between 9am and 5pm or by email at [levyd@nih.gov](mailto:levyd@nih.gov).

If you want to speak to someone not directly involved in the research study, please contact the Boston University Medical Campus (BUMC) Institutional Review Board at (617) 638-7207.



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### ***What will happen in this research exam?***

You will need to fast for 12 hours before you come to the study appointment for the blood draw. You can take your usual morning medication and drink water on the morning of your visit.

**Your research examination will take place at the FHS Research Center at 73 Mount Wayte Avenue, Framingham, MA, or in your home or other residence.** The onsite research exam will take around 4 hours to complete.

### **As before, we will**

- draw a sample of blood for genetic and laboratory tests to better understand risk factors for heart disease and other diseases under investigation (for example, the amount and function of different types of cholesterol in your blood). The total blood draw will be around 120 mL, which is about 8 tablespoons. The blood draw will occur in two stages. The first blood draw soon after your arrival and the second blood draw after the Cardiopulmonary Fitness Evaluation.
- collect a urine sample
- measure your height and weight
- complete an electrocardiogram (ECG)
- record your blood pressure
- update your medical history information
- complete a test of vascular function that tests blood vessel (artery) stiffness by recording the blood pressure waveform
- ask you to sign a form to allow FHS to obtain copies of medical records, including Medicare records. The release form is valid to obtain these records unless canceled by you.
- contact you later by mail, email, or by phone to obtain additional information or to invite you to participate in further FHS related studies. You may also be invited to return for another examination in the future.

### **Surveys**

We will also be asking you to complete questionnaires such as physical function, diet, exercise, memory and mood, and your lifestyle habits, including whether you smoke or use alcohol. Some of the questionnaires you will have seen before and others will be new to you.

Some of your responses will be recorded using a digital audio recorder. Recordings will be analyzed in conjunction with other study information. We will also use recordings to make sure that your responses are accurately documented.

### ***There are some new research activities.***

1. Cardiopulmonary Fitness Evaluation: The Cardiopulmonary Fitness Evaluation is designed to find out the efficiency of your heart, lungs, and circulation of blood. We will ask you to exercise on a stationary cycle while you are attached to machines that will record your breathing and heart function. We will ask you to pedal the cycle for as long as you are able. While you are pedaling you will breathe into a tube that will collect and measure the air you breathe in and out. Your heart rate and blood pressure will be watched throughout this activity. We will monitor your heart rate

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using an electrocardiogram (ECG) by placing small stick-on pads to your skin. This test will take about 30 minutes in total, with about 10-15 minutes spent actually exercising. At the end of this test, a blood sample of around 25 mL, or 2 tablespoons, will be drawn.

*What risks can I expect?* As with any moderate exercise you will become tired and short of breath; this is normal. It is likely that your heart rate and blood pressure will increase. In rare instances, abnormal changes may occur such as fainting, irregular heart beat and low blood pressure. In very rare instances heart attack may occur as in any other strenuous activity. Every effort will be made to minimize any possible problem by constant surveillance during testing as well as the ability to stop the tests at any time. Equipment and trained personnel are available to deal with unusual situations, should they arise.

Minimal bruising, pain, bleeding, or in rare circumstances, infection may occur, as a result of the blood draw. Also, although rare, some people feel lightheaded or faint when their blood is drawn.

2. **Bone Study:** High Resolution-Peripheral Quantitative Computed Tomography bone scan of the forearm and lower leg: While seated, we will place your forearm on a support and then place it inside the machine to take the scan. When we have completed the scan of your arm, we will do the same with your lower leg. It is important that you remain as still as possible for this scan. Dual-energy x-ray absorptiometry scan of the hip and the whole body: This scan involves lying on a padded table and having the machine pass over and scan your hip and your entire body.

*What risks can I expect?* Having bone density tests involve the use of X-rays, which are a form of radiation. However, the radiation that you will be exposed to as part of this study is so small that there is no significant risk to your health.

Due to potential risk to the fetus, pregnant women, as determined by self-report or by a positive pregnancy test, will be excluded from this test.

3. **Desktop AGE Reader (Skin Test):** This test measures the amount of a special type of collagen in the skin of your forearm that can be affected by levels of blood sugar. The amount of the special type of collagen in the skin is related to the amount in the bone. We will clean your arm with a wet wipe. You will then place your bare forearm on the reader and it will shine a light on your skin to perform the measurement.

*What risks can I expect?* There are no known risks associated with the skin reader.

4. **Fibroscan:** The fibroscan is a test to measure the presence of fat or scarring in the liver. A painless pulse is generated on your skin that travels to the liver and measures how stiff your liver is.

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What risks can I expect? There may be minor discomfort from the application of lubricating jelly and pressure on the skin from the fibroscan probe. However, there are no known risks associated with the fibroscan.

There are some conditions that may interfere with the ability of the device to obtain valid measures. They include being pregnant, having fluid in the abdominal cavity (ascites), and having implanted medical devices, such as a heart pacemaker. We will ask, but please let us know if you have any of these conditions and we will not complete the fibroscan.

5. Additional Medical Record Release for Medicare Using Social Security Numbers: You will be asked if investigators and their research collaborators at other institutions, including Duke University, may link your Social Security Number to the Center for Medicare & Medicaid Services data to obtain Medicare information. Social Security Numbers will not be released to outside institutions for purposes not related to the study except with consent or as required by law.

What risks can I expect? We do our best to protect your study information (see below). However there is still a risk of loss of confidentiality.

### **Take home tests:**

6. Electronic FHS (eFHS) Study: If you live in the US, have an email account with access to a daily Internet connection or have an iPhone, we will invite you to take part in the eFHS study. Taking part requires that you download apps and use wireless devices. The apps will require you to complete surveys regarding lifestyle and health, and the devices will measure heart rate, blood pressure, weight, and physical activity.

What risks can I expect? There are no known risks to taking part in this study.

7. Stool Sample Collection: We will ask you if you would like to use a kit to collect a stool sample at home and then to send the sample by mail to a laboratory. The purpose of this study is to better understand the causes of cardiovascular disease and diabetes, by studying what bacteria are present in your gut, and what biological functions they are performing. The take home kit contains instructions and supplies for the stool collection. The kit also contains a sheet with a few questions about how you have been feeling recently, the foods you have been recently eating and the appearance of your stool.

What risks can I expect? The stool sample collection is inconvenient and might make you feel uncomfortable. You may also be uncomfortable answering some of the questions we ask you in the questionnaire that goes with your stool collection kit. You may choose to not answer any questions that you do not feel comfortable

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answering. Your answers will be kept confidential and will not be associated with your name or personal identifying information.

8. Accelerometer: You will be asked to wear a physical activity monitor on a belt for a week and to return it to FHS. It measures how active you are throughout the day.

What risks can I expect? *There are no known risks to taking part in this study.*

General Risks: The research exam is time consuming and repetitive. Other discomforts include headaches, feeling hungry due to fasting, fatigue and chill during the visit. We do not expect any risk of injury as a result of your participation in the study. However, first aid will be available.

Unknown Risks: There may also be some risks that we are unable to determine at this time.

### **Genetic Studies**

We plan to do genetic research on the DNA from your biological samples. The biological samples include blood cells, tissue cells, stool samples, etc. DNA is the material that makes up your genes. Genes are passed from parent to child. All living things are made of cells. Genes are the part of cells that contain the instructions which tell our bodies how to grow and work and determine physical characteristics such as hair and eye color.

Also, if you agree, we will process white blood cells from a sample of your blood to become stem cells in the laboratory. The resulting cells are known as Induced Pluripotent Stem Cells (iPS cells), and they will be used in the laboratory to act like cells from other organs, such as liver cells, fat cells, heart cells, lung cells, vascular cells, gut cells, nerve cells, different types of blood cells, and many other engineered or naturally occurring cell types. These cells and the cell products that can be obtained from them such as RNA, proteins, and metabolites may be studied in laboratories to learn more about the causes of health and diseases of these organs.

Your cells will be stored indefinitely in a stem cell repository at Boston University. Your cells may also be stored in a central repository or bank.

If you agree, your stored tissues, cells and any resulting iPS cell lines or their derivatives could be used in future related and unrelated research studies including:

- Injecting or transplanting the stem cells or their derivatives into animals for research purposes. Your samples may be used in research that involves genetic manipulation but they will not be used to clone or to otherwise create an entire human being.
- Testing for genetic and DNA composition. Genes may be analyzed and/or manipulated to study normal function or development, and some of the DNA in the stem cells or their derivatives may be altered.
- Other uses involving research or development of commercial products for the

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diagnosis, prevention, or treatment of various diseases.

- Samples (blood cells, the iPS cells, or their derivatives) obtained from you in this study may be used in the development of one or more diagnostic or therapeutic products which could be patented and licensed by those involved in the research or development of such products. There are no plans to provide financial compensation to you should this occur.

### *How will I learn the results of this study?*

The main way results of research from this study are reported is in scientific publications and presentations at scientific meetings. Summary findings are also sometimes described in our newsletters.

We will also report some routine research test measurements to you and/or your health care provider at the time of the exam or after your visit. These may include, for example, blood pressure and cholesterol.

In some cases, if we determine it to be appropriate, we may report to you and/or your health care provider research findings as they relate to you, if you give your permission. This information, if it is reported, might be reported long after your visit for a number of reasons. As an example, it might take years of work to analyze information and arrive at research findings, possibly using newly developed scientific methods.

Our genetic research might generate findings that could be relevant to you and possibly your family members, such as information about a particular genetic variant that might put you at risk of a serious health condition. At this time, we believe that most of the genetic research findings do not have medical importance to individuals, but the field of genetics is changing rapidly.

We currently do not have specific plans to contact you or your health care provider about genetic or non-genetic research findings other than some routine research test measurements. In general, we cannot commit to providing any other research findings to you. In determining whether we share additional research information with you, we will take into account a number of considerations on a case-by-case basis. These might include whether the findings were based on tests that are clinically acceptable, accurate and reliable, whether the findings reveal a significant risk of a serious health condition, whether there is at the relevant time a recognized treatment or prevention intervention or other available actions that have the potential to change the clinical course of the health condition, whether reporting or not reporting the results is likely to increase the risk of harm to you, and other relevant factors that we might not be able to predict at this time.

Research test measurements and findings are not the same as clinical test results. As such, our research examination is not necessarily performed by individuals with clinical training and qualifications, and many parts of the examination do not meet the standards for certified clinical testing. For these reasons, our research tests should not be relied on to make any diagnosis,

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treatment, or health planning decisions. We do not provide health care or give medical advice or genetic testing or provide counseling. If you or your health care provider decides that follow-up tests or treatments are necessary, then you (or a third party such as a health insurance carrier or Medicare) will be responsible for the cost.

### ***How are my samples and information shared with other researchers?***

Samples and information will be kept indefinitely. If you agree, your data and donated blood, blood cells, resulting iPS cells or their derivatives, urine, and any other specimens may be shared with other researchers. These include other academic, non-profit, and for-profit entities, including but not limited to hospitals, universities, cell/tissue storage banks and repositories, databanks and data repositories, and businesses, whether for related or unrelated research studies. They will not be labeled with your name or other direct personal identifiers, only a code.

Coded audio recording information will be analyzed by qualifying collaborators inside and outside of BUMC. Your name and other direct personal identifiers will not be shared with these entities.

You have the right to refuse to allow your data and samples to be used or shared for further research. Please check the appropriate box in the selection below.

If you give your permission to allow your data and biological samples to be used or shared for further research, you may withdraw your permission at any time by contacting the FHS investigators. However, if your data or samples have already been released to other researchers, we will not be able to instruct the other researchers to stop using them, to destroy them or products made from them. Your data and samples will not include your name or other direct identifiers.

### ***What risks can I expect?***

Participating in genetic research could have a negative impact on you, your family, and your loved ones. The genetic studies might result in research findings that relate to your risk of a serious health condition or other genetic information that we might consider to be appropriate to report to you and your health care provider, if you wish us to report them (see below). This could present you with some difficult decisions regarding the available information and the disease risks you and your family members might face. Knowledge of genetic research findings can provoke anxiety and influence decisions regarding marriage, family planning, and other matters.

### ***How is my information protected?***

We take steps to make sure that the personal information we collect about you is kept private and secure. We *label* your samples and information with a code, and we keep the key to the code in a password protected database. Only approved staff is given the password. We use other safeguards at our facilities and for our information technology and systems to protect the privacy and security of your information.

*We do not sell, rent, or lease your contact information.*

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If information from this study is published or presented at scientific meetings, and when your samples and information are shared with other researchers and deposited in data and specimen banks and repositories, your name and other direct personal identifiers will not be used.

However, we cannot guarantee total privacy. We may give access to your information in order to do the study and to make sure we do the study according to certain standards set by ethics, law, and quality groups. Information may be made available to researchers that are part of this study, the Institutional Review Board that oversees this research, research and non-research staff and organizations who need the information to do their jobs for the conduct and oversight of the study, people or groups that we hire to do work for us (such as data or biosample storage companies, insurers, and lawyers), and Federal and state agencies as required by law or if they are involved in the research or its oversight. In most cases, any information that is given out to others is identified by code and not with your name or other direct personal identifiers. Once information is given to outside parties, we cannot promise that it will be kept private. Please be aware that your personal information may be given out if required by law (e.g., to prevent possible injury to yourself or others).

To help us further protect your privacy, the investigators have obtained a Certificate of Confidentiality from the Department of Health and Human Services (DHHS). With this Certificate, the investigators cannot be forced (for example by court subpoena) to disclose research information that may identify you in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings. Disclosure will be necessary, however, upon request of DHHS for audit or program evaluation purposes. A Certificate of Confidentiality does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. If an insurer or employer learns of your participation, and obtains your consent to receive research information, then FHS is not allowed to use the Certificate of Confidentiality to withhold this information. This means that you and your family must also actively protect your own privacy. Finally, you should understand that the Certificate of Confidentiality does not prevent the investigators from taking steps, including reporting to authorities, to prevent serious harm to yourself or others.

### ***Patenting Discoveries***

Research from this study may, one day, result in new tests to diagnose or predict diseases. It may also lead to the development of new ways to prevent or treat diseases. As is true of all federally-funded research, researchers and their employers are permitted by Federal law to patent discoveries from which they may gain financially. You and your heirs will not benefit financially.

### ***What are the possible benefits from being in this research study?***

You will not be paid for your participation in this study, and you will not receive any personal health benefits as a result of your participation in this study. We hope that this study will help us better understand what causes heart disease and other diseases and conditions and how to better prevent and treat them.

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### ***What are the costs of taking part in the study?***

Costs that you may incur on the day of your participation include, but are not limited to, loss of work and transportation costs (gas, tolls, etc.).

No special arrangement will be made by the Framingham Heart Study for compensation or payment solely because of your participation in this study. If you think you have been injured by being in this study, please let the investigators know right away. Boston University and the sponsors do not offer a program to provide compensation for the cost of care for research related injury or other expenses such as lost wages, disability, pain, or discomfort. You will be sent a bill for the medical care you receive for research injury if your medical insurance does not pay for your medical care. This does not waive any of your legal rights.

### ***How long will I be in the study?***

FHS is a long term study.

Taking part in this research study is up to you. You can decide not to take part. If you decide to take part now, you can change your mind and drop out later.

We will tell you if we learn new information that could make you change your mind about taking part in this research study.

The investigator may decide to discontinue your participation without your permission because he/she may decide that staying in the study will be bad for you, or the sponsor may stop the study.



## THE FRAMINGHAM HEART STUDY

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**Please read the following statements and check the appropriate box below:**

- 1) I agree to participate in the FHS examination, including the collection of data, blood, urine samples, and various research tests and measurements. I agree to the use of all data, samples, and research materials for studies of the factors contributing to heart and blood vessel diseases, lung and blood diseases, stroke, memory loss, cancer, and other diseases and health conditions.

☐ YES ☐ NO (Office Code 0)

- 2) I agree to allow Induced Pluripotent Stem Cells (iPS cells) to be made from my blood and altered so that they function like cells from other organs.

☐ YES ☐ NO (Office Code 13)

- 3) I agree to allow my data, blood, DNA and other genetic material, iPS cells and their derivatives, urine samples, and any other specimens to be used in genetic research, of factors contributing to heart and blood vessel diseases, lung and blood diseases, stroke, memory loss, cancer, and other diseases and health conditions.

☐ YES ☐ NO (Office Code 3)

- 4) I agree to allow researchers from commercial companies to have access to my data, blood, DNA and other genetic material, iPS cells and their derivatives, urine samples, and any other specimens for research. I understand that my data and specimens will be shared without my name or direct personal identifiers.

☐ YES ☐ NO (Office Code 4)

- 5) I agree to allow the FHS to release the findings of non-genetic research tests and examinations to me and/or my physician, clinic, hospital, or other health care provider.

☐ YES ☐ NO (Office Code 30)

- 6) I agree to allow the FHS to provide me, and with my permission, my physician, clinic, hospital, or other health care provider information relating to genetic research findings as they may relate to me.

☐ YES ☐ NO (Office Code 31)

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## THE FRAMINGHAM HEART STUDY

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Signing this consent form indicates that you have read this consent form (or have had it read to you), that your questions have been answered to your satisfaction, and that you voluntarily agree to participate in this research study. You will receive a copy of this signed consent form.

Participant's Signature	Printed Name	Date
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Legally Authorized Representative (LAR)'s Signature	Printed Name	Date
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Person Obtaining Consent Signature	Printed Name	Date
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## RESEARCH CONSENT FORM

### Blood Draw Consent for Cell Line Creation

THE FRAMINGHAM HEART STUDY N01-HC-25195 1910G

#### Background

A cell line is a frozen sample of specially processed white cells from your blood that allows the Framingham Heart Study to grow more white cells and get more DNA from them in future as needed for research projects.

#### Purpose

A cell line will be created from a blood sample you provide in order to study the cause and prevention of cardiovascular disease and other health conditions, including the possibility of how genetic factors influence health status.

#### What Happens In This Research Study

You will be one of approximately 1080 subjects to be asked to participate in this study.

All or part of the research in this study will take place at the following location(s): Boston University Medical Center.

Your research blood draw will take place at the Framingham Heart Study located at 73 Mount Wayte Avenue in Framingham, MA, or the place where you reside. A laboratory technician will draw a sample of your blood (16 cc or about 1 tablespoon) for the preparation of DNA (genetic material) and for the creation of a living sample of white blood cells (cell line).

#### Risks and Discomforts

Minimal bruising, pain, or bleeding may occur as a result of the blood draw. A latex allergy can occur from the gloves worn by the technician. If you have a known latex allergy, inform the technician and he/she will use another form of protection.

There may be unknown risks/discomforts involved. Study staff will update you in a timely way on any new information that may affect your health, welfare, or decision to stay in this study

#### Potential Benefits

You will receive no direct benefit from your participation in this study. However, your participation may help the investigators better understand the cause and prevention of cardiovascular disease and other health conditions, including the possibility of how genetic factors influence health status.

#### Alternatives

Your alternative is to not participate in the study.

Blood Draw Consent for Cell Line  
Creation Res.v10

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## RESEARCH CONSENT FORM

### Blood Draw Consent for Cell Line Creation

THE FRAMINGHAM HEART STUDY N01-HC-25195 1910G

#### Subject Costs and Payments

You will not be charged for the examination. If the examination finds any medical problems requiring medical diagnosis or treatment, you will be so advised and that information will be provided to the physician or clinic that you choose.

In the event that your physician decides that follow up clinical tests or treatments are necessary, payment must be provided by you or your third party payer, if applicable (for example, health insurance or Medicare). No special arrangements will be made by the Framingham Heart Study for compensation or for payment of treatment solely because of your participation in this study. This does not waive any of your legal rights.

Costs that you might incur the day of your participation include, but are not limited to, transportation costs (gas, tolls, etc). You will not receive payment for your participation. However, if necessary, we will provide transportation to the clinic and your return home at no cost.

#### Confidentiality

Information obtained during this study will be treated as strictly confidential. A code number will be assigned to you and to your personally identifying information. Cell lines will be stored at a central site. Files linking names to samples will be kept locked and accessible only to the Framingham Heart Study (FHS) data managers. The coded samples will be stored securely and kept until no longer of scientific value. The risk in providing this sample is minimal.

Data and DNA will be distributed to the FHS researchers and other qualified researchers interested in the genetics of heart and blood vessel diseases, lung and blood diseases, stroke, memory loss, joint disease, bone loss, deafness, cancer, and other major diseases and health conditions. The researchers will be given the DNA without any personally identifying information. Information gained from research on your DNA may be used for the development of diagnostic procedures or new treatments for major diseases. Your DNA will not be sold to any person, institution, or company for financial gain or commercial profit. However, neither you nor your heirs will gain financially from discoveries made using the information and/or specimens that you provide.

When study results are published, your name and any other identifying information will not be revealed. You will be informed through periodic publications from the FHS of some findings about genetics, cardiovascular disease or other health conditions generated from the DNA analyses.

Blood Draw Consent for Cell Line  
Creation Res.v10

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## RESEARCH CONSENT FORM

### Blood Draw Consent for Cell Line Creation

THE FRAMINGHAM HEART STUDY N01-HC-25195 1910G

To help us further protect your privacy, the investigators have obtained a Confidentiality Certificate from the Department of Health and Human Services (DHHS). With this Certificate, the investigators cannot be forced (for example by court subpoena) to disclose research information that may identify you in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings. Disclosure will be necessary, however, upon request of DHHS for audit or program evaluation purposes. You should understand that a Confidentiality Certificate does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. Note however, that if an insurer or employer learns about your participation, and obtains your consent to receive research information, then the investigator may not use the Certificate of Confidentiality to withhold this information. This means that you and your family must also actively protect your own privacy. Finally, you should understand that the investigator is not prevented from taking steps, including reporting to authorities, to prevent serious harm to yourself or others.

You may choose to withdraw your blood samples and your samples would be destroyed after the request is received. If you choose to withdraw your samples, you should call the Framingham Heart Study at (508) 935-3477 and ask for the lab manager.

The FHS is a medical research project sponsored by the National Institutes of Health. It is authorized under 42USC 285b-3. The system of records which applies to the FHS is documented in the Federal Register: September 26, 2002 (Vol. 67, No. 1879) pages 60776-60780.

Please check the appropriate box below:

1) ☐ YES ☐ NO (Office Code 1)

I agree to allow a cell line to be made from my blood to provide a renewable supply of DNA. (A cell line is a frozen sample of specially processed white cells from your blood that allows us to grow more white cells and obtain more DNA from them as needed for future research projects).

### Subject's Rights

By consenting to participate in this study you do not waive any of your legal rights. Giving consent means that you have heard or read the information about this study and that you agree to participate. You will be given a copy of this form to keep.

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## RESEARCH CONSENT FORM

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If at any time you withdraw from this study you will not suffer any penalty or lose any benefits to which you are entitled.

You may obtain further information about your rights as a research subject by calling the Office of the Institutional Review Board of Boston University Medical Center at 617-638-7207.

The investigator or a member of the research team will try to answer all of your questions. If you have questions or concerns at any time, or if you need to report an injury while participating in this research, contact PHILIP A. WOLF, MD, or DANIEL LEVY, MD, at (508) 872-6562.

### Compensation for Research Related Injury

If you think that you have been injured by being in this study, please let the investigator know right away. If your part in this study takes place at Boston Medical Center, you can get treatment for the injury at Boston Medical Center. If your part in the study is not at Boston Medical Center, ask the investigator where treatment for injury would be available locally. You and your insurance company will be billed for this treatment. Some research sponsors may offer a program to cover some of the treatment costs which are not covered by your insurance. You should ask the research team if such a program is available.

### Right to Refuse or Withdraw

Taking part in this study is voluntary. You have the right to refuse to take part in this study. If you decide to be in the study and then change your mind, you can withdraw from the research. Your participation is completely up to you. Your decision will not affect your being able to get health care at this institution or payment for your health care. It will not affect your enrollment in any health plan or benefits you can get.

If you choose to take part, you have the right to stop at any time. If there are any new findings during the study that may affect whether you want to continue to take part, you will be told about them as soon as possible.

The investigator may decide to discontinue your participation without your permission because he/she may decide that staying in the study will be bad for you, or the sponsor may stop the study.

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## RESEARCH CONSENT FORM

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#### Protection of Subject Health Information

N/A

Signing this consent form indicates that you have read this consent form (or have had it read to you), that your questions have been answered to your satisfaction, and that you voluntarily agree to participate in this research study. You will receive a copy of this signed consent form.

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Subject (Signature and Printed Name) Date

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Legally Authorized Representative (LAR) (Signature and Printed Name) Date

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Person Obtaining Consent (Signature and Printed Name) Date

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Forma de Consentimiento de Investigación para el Grupo 3 Examen 3 del  
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**Bienvenido de Nuevo al Estudio del Corazón de Framingham**

*Juntos estamos ayudando a combatir enfermedades del corazón y otras importantes enfermedades y condiciones de salud a través de la investigación médica.*

**¿Por qué se está haciendo este estudio de investigación?**

El Estudio del Corazón de Framingham (Framingham Heart Study o FHS, por sus siglas en inglés) es un estudio de investigación a largo plazo. El propósito del estudio es:

- (1) Ayudar a comprender cómo se desarrollan enfermedades de corazón y los vasos sanguíneos, enfermedades del pulmón y la sangre, derrames cerebrales, pérdida de memoria, cáncer y otras enfermedades y condiciones de salud importantes; y
- (2) Examinar el ADN y su relación con los riesgos a desarrollar estas enfermedades y otras condiciones de salud.

**El examen que se llevará a cabo como parte de este estudio de investigación no es lo mismo que cuidados médicos en una clínica. Las pruebas son sólo con fines de investigación. No ofrecemos servicios médicos. Este examen no reemplaza su chequeo regular con su médico de cabecera.**

**Acerca de su consentimiento**

Por favor lea cuidadosamente este formulario de consentimiento de investigación. Le da importante información sobre el estudio. Tomar parte en un estudio de investigación es voluntario. La decisión de participar o no, en todo o en parte del examen depende totalmente de usted. Si usted decide participar, puede decidir dejar de hacerlo en cualquier momento. Su decisión será honrada y respetada. No habrá ninguna multa si usted decide dejar de participar.

**¿A quién puedo llamar si tengo preguntas o dudas acerca de este estudio de investigación?**

Si tiene alguna pregunta acerca de este estudio o este formulario, por favor déjenos saberlo. Puede llamarnos con sus preguntas o dudas las veces que quiera.

Puede llamar al personal del estudio en inglés al (508) 872-6562, o en español al (508) 935-3485 o puede enviar un correo electrónico a [FHS@bu.edu](mailto:FHS@bu.edu).

El Estudio del Corazón de Framingham se lleva a cabo por los investigadores de la Universidad de Boston, el Instituto Nacional Cardíaco, Pulmonar y Sanguíneo, y el Instituto Nacional de la Salud. El Dr. Vasan S Ramachandran y el Dr. Daniel Levy están a cargo de la investigación. Puede contactar al Dr. Ramachandran al (617) 638-8090 de lunes a viernes entre 9:00 y 17:00 o por correo electrónico a [vasan@bu.edu](mailto:vasan@bu.edu) y al Dr. Levy al (508) 935-3400 de lunes a viernes entre 9:00 y 17:00 o por correo electrónico a [levyd@nih.gov](mailto:levyd@nih.gov).

Si desea hablar con alguien que no esté directamente involucrado en este estudio de investigación, por favor póngase en contacto con la Junta de Revisión Institucional del Centro Médico de la Universidad de Boston (BUMC) al (617) 638-7207.

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**¿Qué pasará en este examen de investigación?**

Usted necesitará ayunar por 12 horas antes de llegar a su cita debido a la muestra de sangre que tomaremos. Si toma medicinas en la mañana, hágalo como siempre y asegúrese de tomar agua en la mañana de su visita.

**Su examen se llevará a cabo en el Centro de Investigación del Estudio del Corazón de Framingham (FHS) en 73 Mount Wayte Avenue, Framingham, MA, o en su hogar u otra residencia.** El examen aquí tomará alrededor de 4 horas.

**Como en los exámenes anteriores,**

- Tomaremos una muestra de sangre para pruebas genéticas y de laboratorio, para poder comprender mejor los factores de riesgo de enfermedades del corazón y otras enfermedades bajo estudio (por ejemplo, la cantidad y función de diferentes tipos de colesterol en la sangre). La cantidad total de sangre extraída será alrededor de 120 ml, que son unas 8 cucharadas. La toma de sangre se producirá en dos etapas: la primera poco después de su llegada y la segunda después de la evaluación cardio-pulmonar de su condición física.
- Colectaremos una muestra de orina
- Mediremos su peso y altura
- Realizaremos un electrocardiograma (ECG)
- Mediremos su presión arterial
- Actualizaremos su historial clínico
- Haremos una prueba de función vascular para medir la rigidez de los vasos sanguíneos (arterias) mediante el registro de ondas producidas mientras se mide la presión arterial
- Le pediremos que firme un formulario de consentimiento para que nos dé permiso de obtener expedientes médicos incluyendo de Medicare. Este formulario será válido hasta que usted lo cancele
- Le contactaremos más adelante por correo, email o por teléfono, para obtener información adicional o para invitarlo a participar en otros estudios relacionados con FHS. También puede ser invitado a participar de nuevo a otro de nuestros exámenes.

**Encuestas**

También le pediremos que llene unos cuestionarios sobre su función física, dieta, ejercicio, memoria, estado de ánimo y hábitos de vida, incluyendo si fuma o consume alcohol. Algunos de los cuestionarios ya los ha hecho, otros serán nuevos para usted.

Algunas de sus respuestas se grabarán mediante una grabadora audio-digital. Las grabaciones serán analizadas junto con otra información del estudio. También usaremos las grabaciones para asegurarnos que sus respuestas estén documentadas correctamente.

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***Hay algunas nuevas actividades de investigación.***

1. Evaluación del estado cardio-pulmonar: La evaluación de su condición cardio-pulmonar está diseñada para averiguar la eficacia de su corazón, los pulmones y la circulación de la sangre. Le pediremos que haga ejercicio en una bicicleta estacionaria mientras usted esté conectado a máquinas que graban su respiración y función cardíaca. Le pediremos que pedalee tanto como pueda. Mientras pedalea, la respiración se efectuará en un tubo que medirá el aire que inhala y exhala. Se observarán su ritmo cardíaco y la presión arterial a lo largo de esta actividad. Vigilaremos su ritmo cardíaco mediante un electrocardiograma (ECG) colocando pequeños adhesivos a la piel. Esta prueba tomará unos 30 minutos en total, de los cuales 10 a 15 minutos serán haciendo ejercicio. Al final de esta prueba, tomaremos una muestra de sangre de alrededor de 25 ml o 2 cucharadas.

*¿Qué riesgos puedo esperar? Como con cualquier ejercicio moderado, puede cansarse y tener dificultad para respirar; esto es normal. Es probable que aumente la frecuencia cardíaca y presión arterial. En raras ocasiones, pueden ocurrir cambios anormales tales como desmayo, latidos cardíacos irregulares y baja presión arterial. En muy raras ocasiones pudiera ocurrir un ataque cardíaco, como con cualquier otra actividad extenuante. Se hará todo lo posible para reducir al mínimo cualquier posible riesgo vigilándolo constantemente durante la prueba así como pudiendo detener las pruebas en cualquier momento. Equipo especial y nuestro personal capacitado estarán disponibles para hacer frente a situaciones inusuales, si ocurrieran.*

Como resultado de la toma de sangre, pudieran surgir moretones, dolor o sangrado, o en muy raras ocasiones infección. También, aunque raro, algunas personas pueden sentirse mareadas o débiles.

2. Estudio del hueso: Tomografía computarizada de alta resolución periférica cuantitativa del hueso del antebrazo y la pierna: estando sentado, se coloca el antebrazo sobre un soporte y se coloca dentro de la máquina para tomar el examen. Después haremos lo mismo con su pierna. Es importante que se mantenga lo más quieto posible durante este escaneo. Exploración de absorciometría de rayos x de energía dual de la cadera y todo el cuerpo: esta prueba implica recostarse en una mesa acolchada. La máquina de escaneo pasará sobre su cadera y todo su cuerpo.

*¿Qué riesgos puedo esperar? Las pruebas de densidad ósea implican el uso de rayos x, que son una forma de radiación. Sin embargo, la radiación a la que estará expuesto como parte de este estudio es tan pequeña que no hay ningún riesgo significativo para la salud.*

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Debido al riesgo potencial para un feto, las mujeres que estén embarazadas, ya sea porque lo hayan reportado directamente o porque en nuestra prueba de embarazo hayan salido positivas, serán excluidas de este examen del hueso.

3. **Medidor de edad (prueba cutánea):** Esta prueba mide la cantidad de un tipo especial de colágeno en la piel de su antebrazo que puede ser afectado por los niveles de azúcar en la sangre. La cantidad de este tipo especial de colágeno en la piel se relaciona con la cantidad en el hueso. Limpiaremos el brazo con un trapo mojado. Luego colocaremos su antebrazo en el aparato de escaneo y una luz brillará sobre su piel para realizar la medición.

*¿Qué riesgos puedo esperar? No existen riesgos conocidos asociados con este escaneo de la piel.*

4. **FibroScan:** El fibroscan es un examen para medir la presencia de grasa o cicatrices en el hígado. Se genera un pulso sin dolor que viaja al hígado y mide su dureza.

*¿Qué riesgos puedo esperar? Puede haber pequeñas molestias por la aplicación del gel y la presión sobre la piel con la punta del aparato fibroscan. Sin embargo no hay riesgos conocidos asociados con el fibroscan.*

*Hay algunas condiciones que pueden interferir con la capacidad del dispositivo para obtener medidas válidas. Estas incluyen: estar embarazada, tener líquido en la cavidad abdominal (ascitis) y tener implantes médicos, como un marcapasos. Le preguntaremos sobre esto, pero por favor, háganos saber si tiene alguna de estas condiciones para no realizar el fibroscan.*

5. **Petición adicional para pedir registros médicos a Medicare usando su número de seguro social:** Se le preguntará si investigadores del estudio, así como colaboradores de otros institutos, incluyendo la Universidad de Duke, pueden relacionar su número de seguro social con la base de datos de Medicare y Medicaid para obtener información de Medicare. Los número de seguro social no serán compartidos con ninguna institución no relacionada con el Estudio del Corazón de Framingham, excepto con su consentimiento o como lo requiera la ley.

*¿Que riesgos puedo esperar? Hacemos nuestro mejor esfuerzo para proteger su información del estudio (véase abajo). Sin embargo aún existe el riesgo de pérdida de confidencialidad.*

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**Pruebas para llevar a casa:**

6. Estudio electrónico del FHS (eFHS): Si vive en los Estados Unidos, tiene correo electrónico y acceso diario a internet o un iPhone, le invitamos a participar en el estudio eFHS. Tomar parte requiere que descargue aplicaciones y use dispositivos inalámbricos. Las aplicaciones requieren completar encuestas sobre salud y estilo de vida. Los dispositivos electrónicos miden la frecuencia cardíaca, presión arterial, peso y actividad física.

*¿Qué riesgos puedo esperar? No existen riesgos conocidos por participar en este estudio.*

7. Colección fecal: Le preguntaremos si desea realizar otro estudio en casa, para enviar sus heces por correo a un laboratorio. El propósito de este estudio es entender mejor las causas de enfermedades cardiovasculares y diabetes mediante el estudio de las bacterias que están presentes en el intestino y las funciones biológicas que éstas realizan. El kit casero contiene instrucciones y todo lo necesario para la colección de materia fecal, así como una hoja con preguntas sobre cómo se ha sentido recientemente, los alimentos que haya estado comiendo recientemente y el aspecto de las heces.

*¿Qué riesgos puedo esperar? Colectar heces pudiera hacerlo sentir incómodo. Así como responder a algunas preguntas del cuestionario del kit de colección de heces. Usted puede elegir no contestar las preguntas que no quiera responder. Sus respuestas se mantendrán confidenciales y no se asociarán a su nombre ni a su información de identificación personal.*

8. Acelerómetro: Se le preguntará si quiere usar un monitor de actividad física por una semana. Se pone en un cinturón y se envía de vuelta al FHS. Mide qué tan activo está usted durante el día.

*¿Qué riesgos puedo esperar? No existen riesgos conocidos por participar en este estudio.*

Riesgos Generales: Este estudio lleva tiempo y es repetitivo. Otras molestias incluyen dolor de cabeza, el sentirse con hambre o frío y tener fatiga mientras está aquí. No esperamos ningún riesgo a que se lesione como resultado de su participación en el estudio. Sin embargo, tenemos disponibles primeros auxilios.

Riesgos Desconocidos: Existe la posibilidad de otros riesgos que no hemos identificado hasta el momento.

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**Estudios genéticos**

Planeamos hacer investigaciones genéticas con el ADN de sus muestras biológicas, las cuales incluyen células sanguíneas, células de los tejidos, heces, etc. El ADN es el material de lo que están hechos sus genes. Los genes pasan del padre y la madre al niño. Todos los seres vivos están compuestos de células. Los genes son la parte de las células que contienen las instrucciones para decirle a nuestro cuerpo cómo crecer y trabajar, y determinar sus características físicas; como cabello y color de ojos.

También, si está de acuerdo, en un laboratorio procesaremos las células blancas de la sangre de una de sus muestras para convertirlas en células madre. Las células resultantes son conocidas como células madre con pluripotencialidad inducida (células iPS), y se utilizan en el laboratorio para que actúen como células de otros órganos; tales como células del hígado, células grasas, células del corazón, células pulmonares, vasculares, intestinales, células nerviosas, diferentes tipos de células sanguíneas y muchos otros tipos de células naturales. Estas células y los productos celulares que pueden obtenerse de ellas; tales como RNA, proteínas y metabolitos, pueden ser estudiados en laboratorios para aprender más sobre las causas de la salud o enfermedad de éstos órganos.

Las células serán guardadas indefinidamente en un repositorio de células madre en la Universidad de Boston. Las células también pueden almacenarse en un repositorio central o banco.

Si está de acuerdo, sus tejidos, células o cualquier línea de células iPS o sus derivados, podrían ser usados en el futuro para estudios relacionados y no-relacionados como:

- Inyección o trasplante de células madre o sus derivados a animales para fines de investigación. Sus muestras podrían ser usadas en estudios que involucren manipulación genética pero jamás serán usadas para clonar o reproducir a un ser humano completo.
- Pruebas genéticas y composición del ADN. Los genes pueden ser analizados o manipulados para estudiar su función normal y desarrollo. El ADN de algunas células madre o sus derivados, podría ser alterado.
- Otros usos que implican investigación o desarrollo de productos comerciales para el diagnóstico, prevención o tratamiento de diversas enfermedades.
- Muestras obtenidas de usted en este estudio (células sanguíneas, células iPS o sus derivados) pueden ser utilizadas en el desarrollo de uno o más productos terapéuticos o de diagnóstico que podrían ser patentadas y autorizadas por los investigadores involucrados en la investigación o en el desarrollo de estos productos. No hay planes para proporcionar compensación económica si esto ocurriera.

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**¿Cómo puedo saber los resultados de este estudio?**

La principal manera en que los resultados de este estudio son reportados, es a través de publicaciones científicas y con presentaciones en reuniones científicas. En nuestros boletines anuales a veces describimos resúmenes de los resultados.

También informaremos los resultados de mediciones rutinarias de investigación a usted o su proveedor de atención médica en el momento del examen o después de su visita. Estos pueden incluir por ejemplo, la presión arterial y el colesterol.

En algunos casos, si determinamos que es apropiado, podemos reportarle a usted y/o a su proveedor de atención médica los hallazgos de investigación que se relacionen con usted, si nos da su permiso. Esta información, si se da a conocer, podría tomar mucho tiempo después de su visita por una serie de razones: por ejemplo, podría llevar años de trabajo para analizar la información y llegar a resultados de investigación, quizás utilizando métodos científicos que han sido desarrollados solo recientemente.

Nuestra investigación genética podría generar resultados que sean relevantes para usted y posiblemente su familia; tales como información sobre una variante genética particular que lo pudiera poner en riesgo de una condición de salud grave. Por el momento, pensamos que la mayoría de los hallazgos de investigación genética no tienen gran importancia médica para las personas, pero el campo de la genética está cambiando rápidamente.

Actualmente no tenemos planes concretos de contactarlo a usted o a su proveedor de salud sobre los resultados de las diferentes investigaciones genéticas o no-genéticas excepto por las mediciones de pruebas rutinarias de la investigación. En general, no nos podemos comprometer a proporcionarle otros resultados del estudio. En cuanto a determinar si compartimos información adicional de la investigación con usted, tendremos en cuenta una serie de consideraciones según cada caso en particular. Estos pueden incluir si los hallazgos se basaron en pruebas que son clínicamente aceptables, precisas y fiables, si los resultados revelan un riesgo significativo de una condición de salud grave, si existe en el momento pertinente un tratamiento reconocido o la intervención de prevención u otras acciones disponibles que tienen el potencial para cambiar el curso clínico de la condición de salud, si informar o no informar los resultados pudiera aumentar el riesgo de daño a usted, y otros factores relevantes que quizá no seamos capaces de predecir en este momento.

Las mediciones y resultados de una investigación científica no equivalen a los resultados de pruebas clínicas. Como tal, nuestro examen de investigación no se realiza necesariamente por personas calificadas con formación clínica, y muchas partes de la examinación no cumplen con las normas requeridas para pruebas clínicas certificadas. Por esta razón, nuestras pruebas de investigación no son confiables para hacer diagnósticos, tratamientos ni decisiones para planes de salud. No proporcionar una atención de salud o dar consejos médicos o pruebas genéticas o

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brindar asesoramiento. Si usted o su proveedor de atención médica decide hacer pruebas adicionales de seguimiento o los tratamientos necesarios, usted (o un tercero, como un seguro de salud o Medicare) será responsable por esos costos.

**¿Cómo son compartidas mis muestras y mi información con otros investigadores?**

Las muestras e información serán guardadas indefinidamente. Si está de acuerdo, su datos y sangre donada, células de sangre, células iPS o sus derivados, orina y otros especímenes pueden ser compartidos con otros investigadores; incluyendo otras entidades académicas con o sin fines de lucro, como hospitales, universidades, bancos de almacenamiento de células/tejidos y repositorios, bases de datos y repositorios de datos y empresas (ya sea con fines relacionados o no con estudios de investigación). Ninguna muestra o información será etiquetada con su nombre o ningún otro identificador personal. Solo con códigos.

Información de grabaciones de audio codificadas, será analizada por colaboradores calificados dentro y fuera de BUMC. Su nombre y otros identificadores personales directos, no se compartirán con estas entidades.

Usted tiene el derecho a negarse a permitir que sus datos y muestras sean usadas o compartidas para investigación adicional. Por favor marque la casilla apropiada en la lista de abajo.

Si usted da su permiso para que sus datos y muestras biológicas sean utilizadas o compartidas para investigación adicional, usted podrá retirar su autorización en cualquier momento poniéndose en contacto con los investigadores de FHS. Sin embargo, si sus datos o muestras ya han sido compartidas con otros investigadores, no seremos capaces de instruirles para dejar de usarlas o destruirlas, así como los productos hechos de estas muestras. Sus datos y muestras no incluirán su nombre ni otros identificadores directos.

**¿Qué riesgos puedo esperar?**

Participar en investigación genética podría tener un impacto negativo para usted, su familia y sus seres queridos. Los estudios genéticos podrían producir resultados en la investigación que se relacionen con riesgos a una condición de salud seria u otra información genética que podríamos considerar apropiado informarle a usted y su proveedor de atención médica, si es que lo desea (véase abajo). Esto podría presentarle con decisiones difíciles respecto a la información disponible y correr el riesgo de saber sobre enfermedades que usted y sus miembros familiares pudieran enfrentar. Saber los resultados de una investigación genética podría ocasionar ansiedad, e influir en decisiones relativas a matrimonio, planificación familiar y otros temas.

**¿Cómo está protegida mi información?**

Tomamos medidas para cerciorarnos de que la información personal que recopilamos acerca de usted se mantenga privada y segura. Etiquetamos sus muestras e información con un código, y mantenemos las claves de los códigos en una base de datos protegida con

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contraseña. Sólo al personal autorizado se da la contraseña. Usamos otros medios seguros en nuestras instalaciones, sistemas y tecnología para proteger su seguridad y su información. *No vendemos, rentamos ni arrendamos su información de contacto.*

Su nombre y otros identificadores personales directos no se usan cuando la información de este estudio es publicada o presentada en reuniones científicas, ni cuando sus muestras o información se comparten con otros investigadores, ni cuando las guardamos en repositorios y bancos de muestras y datos.

Sin embargo, no garantizamos la privacidad total. Nosotros podemos dar acceso a su información para realizar el estudio y para asegurarnos de que hacemos el estudio según las normas establecidas por la ética, el derecho y grupos de calidad. La información puede hacerse disponible a los investigadores que forman parte de este estudio, pero también a la Junta de Revisión Institucional que dirige esta investigación, a empleados y organizaciones que necesitan la información para hacer su trabajo en la realización y supervisión del estudio, personas o grupos que nos contratan para trabajar para nosotros (como empresas de almacenamiento de datos o “biosample”, compañías de seguros y abogados) y organismos federales y estatales, según lo exija la ley o si están implicados en la investigación o supervisión de nuestro estudio. En la mayoría de los casos, cualquier información que se da es identificada con códigos y no con su nombre u otros identificadores personales directos. Una vez que se da información a terceros, no podemos prometer que será mantenida privada. Tenga en cuenta que su información personal puede darse si es requerida por la ley (como por ejemplo, para evitar posibles lesiones a usted o a otros).

Para ayudar a proteger su privacidad, los investigadores han obtenido un certificado de confidencialidad del Departamento de Salud y Servicios Humanos (DHHS). Con este certificado, los investigadores no pueden ser forzados (por ejemplo mediante citación del Tribunal) a revelar información que pueda identificarlo en ningún procedimiento legislativo civil, penal, administrativo, federal, estatal o local, ni en otros procedimientos del estudio. Sin embargo, sí se puede dar a petición del DHHS y para fines de auditoría o para evaluar el programa. Un certificado de confidencialidad no impide que usted o un miembro de su familia voluntariamente otorgue información sobre usted o su participación en este estudio. Si un asegurador o empleador se entera de su participación y obtiene su consentimiento para recibir información de la investigación, FHS no está permitido utilizar el certificado de confidencialidad para ocultar esta información. Esto significa que usted y su familia también deben proteger su propia privacidad. Por último, debe entender que el certificado de confidencialidad no impide a los investigadores tomar ciertas medidas, como informar a las autoridades, para evitar daños graves a usted o a otros.

### **Patente de Descubrimientos**

Un día, la investigación de este estudio resultará en nuevas pruebas para diagnosticar o predecir enfermedades. También puede llevar al desarrollo de nuevas formas de prevenir o tratar enfermedades. Como es el caso de todas las investigaciones financiadas por el gobierno

Forma de Consentimiento de Investigación para el Grupo 3 Examen 3 del  
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federal, los investigadores y sus empleadores son permitidos por la Ley Federal de Patentes de Descubrimientos, ganar financieramente. Ni usted ni sus herederos se beneficiarán financieramente.

**¿Cuáles son los posibles beneficios de mi participación en este estudio?**

A usted no se le pagará por participar en el estudio ni obtendrá beneficios médicos como resultado de su participación. Sin embargo, esperamos que este estudio nos ayude a comprender mejor qué es lo que causa enfermedades del corazón y otras enfermedades y condiciones, así como las mejores maneras de prevenir y tratar estas enfermedades.

**¿Cuáles son mis costos por tomar parte en el estudio?**

Los costos que pudiera incurrir el día de su participación incluyen, pero no están limitados a, costos de transporte (gasolina, peajes, etc) y el no poder trabajar el tiempo que esté aquí.

El Estudio del Corazón de Framingham no hará arreglos especiales de compensación o pago por su participación en este estudio. Si piensa que ha sufrido una lesión por estar en este estudio, por favor, dígaselo a los investigadores de inmediato. La Universidad de Boston y los patrocinadores del estudio, no ofrecen un programa de compensación debido al costo por la atención médica que pudiera recibir si sufriera lesiones, discapacidad, dolor, malestar u otros gastos, como pérdida de salario. Si sufriera lesiones aquí y si su seguro médico no cubriera su atención médica, no le compensaremos por el gasto de la atención médica que reciba. Esto no renuncia a ninguno de sus derechos legales.

**¿Cuánto tiempo estaré en el estudio?**

El Estudio del Corazón de Framingham es un estudio a largo plazo.

Tomar parte en este estudio depende solo de usted. Si decide tomar parte hora, puede cambiar de parecer y dejar de participar en el futuro.

Le haremos saber si encontramos información nueva que pudiera hacerlo cambiar de parecer respecto a su participación en este estudio.

El investigador puede decidir suspender su participación sin su permiso, por el hecho de que él o ella pueda decidir que seguir en el estudio sería malo para usted, o porque nuestro patrocinador deje de dar fondos para el estudio.

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**Por favor lea las siguientes afirmaciones y marque la casilla apropiada abajo:**

- 1) Estoy de acuerdo en participar en el examen del FHS, que incluye colección de datos, sangre, muestras de orina y varias pruebas de investigación y mediciones. Estoy de acuerdo en que se usen mis datos, muestras y materiales de investigación para los estudios de factores que contribuyen a enfermedades del corazón, los vasos sanguíneos, los pulmones y la sangre, movimiento, pérdida de memoria, cáncer y otras enfermedades y condiciones de salud.

☐ SI ☐ NO (Office Code 0)

- 2) Estoy de acuerdo en permitir que se hagan células con pluripotencialidad inducida (células iPS) de mi sangre y que sean alteradas para que funcionen como células de otros órganos.

☐ SI ☐ NO (Office Code 13)

- 3) Estoy de acuerdo en permitir que mis datos, sangre, ADN y otro material genético, células iPS y sus derivados, muestras de orina y otros especímenes sean utilizados en la investigación genética de factores que contribuyen a enfermedades del corazón y los vasos sanguíneos, pulmón y enfermedades de la sangre, accidentes cerebrovasculares, pérdida de memoria, cáncer y otras enfermedades y condiciones de salud.

☐ SI ☐ NO (Office Code 3)

- 4) Estoy de acuerdo en permitir que investigadores de empresas comerciales tengan acceso a mis datos, sangre, ADN y otro material genético, células iPS y sus derivados, muestras de orina y otros especímenes para investigación. Entiendo que mis datos y muestras se compartirán sin mi nombre o identificadores personales directos.

☐ SI ☐ NO (Office Code 4)

- 5) Estoy de acuerdo en permitir que el FHS comparta conmigo, mi doctor, clínica, hospital u otro proveedor de salud, los resultados de los exámenes y las pruebas de investigación no-genéticas.

☐ SI ☐ NO (Office Code 30)

- 6) Estoy de acuerdo en permitir que el FHS me dé, y con mi permiso también a mi médico, clínica, hospital u otro proveedor de salud, información relativa a la investigación genética referente a mí.

☐ SI ☐ NO (Office Code 31)

Forma de Consentimiento de Investigación para el Grupo 3 Examen 3 del  
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Firmar este formulario de consentimiento indica que usted ha leído este formulario de consentimiento (o se lo han leído a usted), que sus preguntas han sido contestadas a su satisfacción, y que acepta voluntariamente a participar en este estudio de investigación. Usted recibirá una copia de este formulario de consentimiento firmado.

Firma del participante		Nombre con Letra de Molde		Fecha
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Firma del representante legal autorizado (LAR)		Nombre con Letra de Molde		Fecha
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Firma de la persona que obtiene el consentimiento		Nombre con Letra de Molde		Fecha
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## FORMA DE CONSENTIMIENTO PARA INVESTIGACION

### Consentimiento para crear una línea de células de su muestra de sangre ESTUDIO DEL CORAZON DE FRAMINGHAM N01-HC-25195 1910G

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#### Antecedentes

Una línea de células es una muestra congelada de células blancas de su sangre, que han sido especialmente procesadas para que el Estudio del Corazón de Framingham pueda reproducir más células blancas y así obtener más ADN, según se vaya necesitando para futuros estudios.

#### Propósito

Una línea de células será creada de una muestra de sangre que usted nos dé, para estudiar las causas de enfermedades del corazón y otras condiciones de salud, cómo prevenirlas y la posibilidad de estudiar la influencia de los factores genéticos para la salud.

#### Que Sucede en este Estudio de Investigación

Usted será una de las aproximadamente 1080 personas a quienes se les pedirá que participen en este estudio. Todo o parte del estudio se realizará en El Centro Médico de la Universidad de Boston (Boston University Medical Center o BUMC por sus siglas en Inglés).

La muestra de su sangre será tomada en el Estudio del Corazón de Framingham, localizado en 73 Mt. Wayte Ave. en Framingham, MA, o en su lugar de residencia. Un técnico tomará una muestra de su sangre (16 cc o alrededor de 1 cucharada) para la preparación de ADN (material genético) y para la creación de una muestra de células blancas vivas (línea de células).

Los riesgos de dar la muestra de sangre incluyen un pequeño moretón, dolor o sangrado.

También puede ocurrir una alergia al látex. Si sabe que es alérgico al latex, por favor dígaselo al técnico para que use otro tipo de protección.

#### Riesgos y molestias

Pudiera haber riesgos y molestias hasta ahora desconocidos. Los empleados del estudio le actualizarán sobre cualquier información nueva que pudiera afectar su salud, su bienestar y su decisión de seguir participando en el estudio.

#### Posibles Beneficios

Usted no recibirá ningún beneficio directo de su participación en este estudio. Sin embargo, su participación puede ayudar a los investigadores a comprender mejor las causas y prevención de enfermedades cardiovasculares y otras condiciones de la salud, incluyendo la posibilidad de saber cómo los factores genéticos influyen el estado de salud.

#### Alternativas

Tiene la alternativa de no participar en el estudio.

#### Costos y pagos

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## FORMA DE CONSENTIMIENTO PARA INVESTIGACION

### Consentimiento para crear una línea de células de su muestra de sangre ESTUDIO DEL CORAZON DE FRAMINGHAM N01-HC-25195 1910G

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No se le cobrará por este examen. Si en su examen se descubriera algún problema médico que requiera más diagnóstico o tratamiento, se le avisará a usted y a su doctor o a la clínica que usted nos indique.

En caso de que su doctor decida que usted debe someterse a más exámenes clínicos o más tratamientos, estos deberán ser pagados ya sea por usted o por una tercera persona (por ejemplo su seguro médico o Medicare). No se harán arreglos especiales por compensaciones o pagos de tratamientos por el solo hecho de haber participado en este estudio. Este párrafo no cancela sus derechos legales.

Los gastos que puede incurrir el día de su participación incluyen (pero no se limitan) a costos de transportación (gasolina, peaje, etc.). A usted no se le pagará por participar en el estudio. Sin embargo, si fuera necesario, le proveeremos con transportación a la clínica y de vuelta a su hogar sin costo para usted.

#### Confidencialidad

La información obtenida durante el estudio será tratada con estricta confidencialidad. Se le asignará un código a usted y a cualquier información personal que pudiera identificarle. Las líneas de células serán guardadas en un lugar central. Los documentos que vinculen los nombres con las muestras serán guardados bajo llave y serán accesibles solo a los administradores de bancos de datos del Estudio del Corazón de Framingham. Las muestras con códigos serán guardadas hasta que ya no tengan valor científico. El riesgo en proveer esta muestra es mínimo.

La información de datos y el ADN será distribuido a los investigadores del Estudio del Corazón de Framingham y a investigadores calificados interesados en la genética de enfermedades del corazón y las venas, enfermedades del pulmón y la sangre, accidentes cerebro-vasculares, pérdida de memoria, enfermedades de las articulaciones, pérdida de densidad ósea, sordera, cáncer, y otras enfermedades graves y condiciones de salud. A los investigadores se les dará el ADN sin ningún dato que pudiera identificar a los donadores. La información obtenida de su ADN puede ser utilizada para el desarrollo de procedimientos para diagnosticar o para nuevos tratamientos de enfermedades graves. Su ADN no será vendido a ninguna persona, institución o compañía por ganancia financiera ni por beneficio comercial. Sin embargo, ni usted ni sus familiares ganarán provecho financiero de los descubrimientos hechos usando la información o especímenes que usted nos dé.

Cuando los resultados sean publicados, su nombre y cualquier otra información que lo pudiera identificar, no serán revelados. Se le mantendrá informado a través de publicaciones periódicas del Estudio del Corazón de Framingham sobre descubrimientos de genética, enfermedades cardiovasculares y otras condiciones de salud que hayan sido generadas de los análisis del ADN.

## FORMA DE CONSENTIMIENTO PARA INVESTIGACION

### Consentimiento para crear una línea de células de su muestra de sangre ESTUDIO DEL CORAZON DE FRAMINGHAM N01-HC-25195 1910G

Para ayudarnos a proteger su privacidad, los investigadores calificados han obtenido un Certificado de Confidencialidad del Departamento de Salud y Derechos Humanos (DHHS). Con este certificado, los investigadores no pueden ser forzados (por ejemplo por la corte) a divulgar ninguna información que le pueda identificar en ningún procedimiento federal, estatal, local civil, criminal, administrativo, legislativo o ningún otro procedimiento. Sin embargo, el suministro de información será necesario si fuera requerido para una auditoría o evaluación del programa por parte del Departamento de Salud y Derechos Humanos. Por favor comprenda que un Certificado de Confidencialidad no lo previene a usted ni a su familia de voluntariamente suministrar información de usted mismo, ni de su participación en este estudio. Por ejemplo, si un asegurador o empleador sabe que usted es participante de este Estudio, y obtiene el consentimiento de usted mismo para obtener más información, en ese caso el investigador no podrá usar su Certificado de Confidencialidad para no divulgar su información. Esto significa que usted y su familia también deben actuar para proteger su propia privacidad. Finalmente, por favor comprenda que el investigador no está prevenido de tomar las medidas necesarias (incluyendo reportar a autoridades) para prevenir daños severos a usted mismo y a otros.

Tiene la opción de retirar su muestra de sangre en el futuro, en cuyo caso la muestra será destruida. Si elije retirar sus muestras, deberá comunicarse con la encargada del laboratorio del Estudio del Corazón de Framingham al 508-935-3477.

El Estudio del Corazón de Framingham es un proyecto de investigación médica patrocinado por los Institutos Nacionales de la Salud. Autorizado bajo 42USC285b-3. El sistema de registros aplicado al Estudio del Corazón de Framingham, está documentado en el Registro Federal: Septiembre 26, 2002 (Vol. 67, No. 1879) páginas 60776-60780.

**Por favor cheque en la casilla apropiada si está o no está de acuerdo con el siguiente estatuto:**

1. ☐ SI ☐ NO ( Office Code 1)

Estoy de acuerdo en permitir la formación de una línea de células hecha con mi sangre para proveer un suministro renovable de ADN. (Una línea de células es una muestra de células blancas de su sangre, congeladas y procesadas, para poder reproducir más células blancas y así obtener más ADN para futuros estudios).

### Derechos del Participante

Al darnos su consentimiento para participar en este estudio, usted no renuncia a ninguno de sus derechos legales. Dar consentimiento significa que usted ha escuchado o leído la información sobre este estudio y que está de acuerdo en participar. Se le dará una copia de

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## FORMA DE CONSENTIMIENTO PARA INVESTIGACION

### Consentimiento para crear una línea de células de su muestra de sangre ESTUDIO DEL CORAZON DE FRAMINGHAM N01-HC-25195 1910G

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esta forma.

Si en cualquier momento decidiera no seguir participando en este estudio, no sufrirá ningún tipo de penalidad ni perderá ningún beneficio al que tuviera derecho.

Puede obtener más información sobre sus derechos como sujeto en el estudio llamando a la Oficina de Revisión Institucional del Comité de Protección de Derechos Humanos del Centro Médico de la Universidad de Boston al 617-638-7207.

El investigador o algún miembro del equipo de investigadores tratará de responder a todas sus preguntas. Si en cualquier momento tiene preguntas o dudas, o si necesita reportar alguna herida ocurrida durante su participación en esta investigación, por favor comuníquese con el DR. PHILIP A. WOLF, o con el DR. DANIEL LEVY, al (508) 872-6562.

### Compensación por daños relacionados con la Investigación

Si piensa que ha sido herido por participar en este estudio, por favor déjeselo saber al investigador inmediatamente. Si su participación es en el Centro Médico de Boston, puede obtener tratamiento por la herida en el Centro Médico de Boston. Si su participación NO es en el Centro Médico de Boston, pregúntele a su investigador dónde puede obtener tratamiento localmente para la herida. Usted y su seguro médico recibirán la cuenta por el tratamiento recibido. Algunos patrocinadores de investigación ofrecen un programa para cubrir parte de los costos del tratamiento que no son cubiertos por su seguro médico. Debería preguntarle al equipo de investigación si tal programa está disponible.

### Sus Derechos a Rehutar o Descontinuar

Su participación en este estudio es voluntaria. Tiene el derecho de rehusar tomar parte en el estudio. Si decide participar y después cambia de opinión, puede salirse del estudio. Su participación es totalmente opcional. Su decisión no afectará el cuidado médico que pueda recibir en esta institución ni el pago de su cuidado médico. No afectará su inscripción a seguros médicos o beneficios que pudiera obtener.

Si decide tomar parte, tiene el derecho a descontinuar su participación en cualquier momento. Si hubiera nuevos descubrimientos durante la investigación que pudieran afectar su voluntad de participar, se lo harán saber lo más pronto posible.

Es posible que el investigador decida descontinuar su participación sin su permiso, porque pudiera decidir que continuar en el estudio será malo para usted o porque nuestro patrocinador interrumpa el estudio.

Firmar esta forma de consentimiento indica que usted ha leído esta forma (o se la han leído), que sus preguntas han sido contestadas a su satisfacción y que usted voluntariamente accede a participar en este estudio de investigación. Usted recibirá una copia de esta forma de consentimiento firmada.

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**FORMA DE CONSENTIMIENTO PARA INVESTIGACION**

**Consentimiento para crear una línea de células de su muestra de sangre**  
**ESTUDIO DEL CORAZON DE FRAMINGHAM N01-HC-25195 1910G**

_____ _____ Firma del Participante y Nombre con Letra de Molde	_____ Fecha
_____ _____ Representante legal autorizado (LAR) firma y nombre con Letra de Molde	_____ Fecha
_____ _____ Firma de la Persona que Obtiene el Consentimiento y Nombre	_____ Fecha

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# Framingham Heart Study

Generation 3, NOS, Omni 2

## EXAM 3

### Research Center Questionnaire

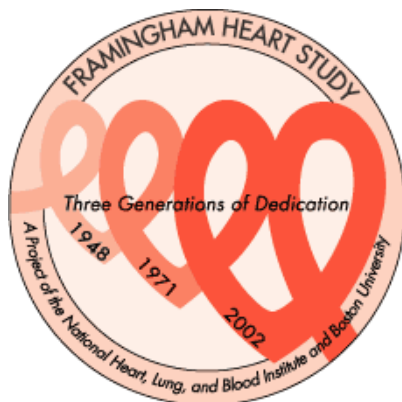
SECTIONS:

Admit	(pages 1 – 6) plus consents
MD	(pages 7 – 112)
Self-Administered Questions	(pages 113 – 142)
Tech	(pages 143 – 174)
Tonometry	(pages 175– 177)

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## MD Section





# Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

## Medical Encounters

1st Examiner ID

Since you last provided medical information ([lastmedinfodate]) have you had any of the following?

Hospitalizations (not E.R.)?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

Hospitalization #1

Reason

Year

2002-2021,  
9999 = Unknown

<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input type="text"/>
<b>Name of hospital</b>	<input type="text"/>
<b>Location of hospital</b>	<input type="text"/> City, State
<b>Have you had another hospitalization?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Hospitalization #2

<b>Reason</b>	<input type="text"/>
<b>Year</b>	<input type="text"/> 2002-2021, 9999 = Unknown
<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input type="text"/>
<b>Name of hospital</b>	<input type="text"/>
<b>Location of hospital</b>	<input type="text"/> City, State
<b>Have you had another hospitalization?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Hospitalization #3

<b>Reason</b>	<input type="text"/>
<b>Year</b>	<input type="text"/> 2002-2021, 9999 = Unknown
<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input type="text"/>
<b>Name of hospital</b>	<input type="text"/>
<b>Location of hospital</b>	<input type="text"/> City, State
<b>Have you had another hospitalization?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Hospitalization #4

**Reason**

**Year**

2002-2021,  
9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

**Name of hospital**

**Location of hospital**

City, State

If participant has had more than 4 hospitalizations, provide details in "Additional Comments" below.

**E.R. visits only?**

- ☐ No  
☐ Yes  
☐ Unknown

**If "Yes"**

E.R. Visit #1

**Reason**

**Year**

2002-2021,  
9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

**Name of hospital**

**Location of hospital**

City, State

**Have you had another E.R. visit?**

- ☐ No  
☐ Yes  
☐ Unknown

E.R. Visit #2

**Reason**

**Year**

2002-2021,  
9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

<b>Name of hospital</b>	<input style="width: 90%;" type="text"/>
<b>Location of hospital</b>	<input style="width: 90%;" type="text"/> <small>City, State</small>
<b>Have you had another E.R. visit?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

E.R. Visit #3

<b>Reason</b>	<input style="width: 90%;" type="text"/>
<b>Year</b>	<input style="width: 90%;" type="text"/> <small>2002-2021, 9999 = Unknown</small>
<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input style="width: 90%;" type="text"/>
<b>Name of hospital</b>	<input style="width: 90%;" type="text"/>
<b>Location of hospital</b>	<input style="width: 90%;" type="text"/> <small>City, State</small>
<b>Have you had another E.R. visit?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

E.R. Visit #4

<b>Reason</b>	<input style="width: 90%;" type="text"/>
<b>Year</b>	<input style="width: 90%;" type="text"/> <small>2002-2021, 9999 = Unknown</small>
<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input style="width: 90%;" type="text"/>
<b>Name of hospital</b>	<input style="width: 90%;" type="text"/>
<b>Location of hospital</b>	<input style="width: 90%;" type="text"/> <small>City, State</small>

**If participant has had more than 4 E.R. visits, provide details in "Additional Comments" below.**

<b>Day surgery?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
---------------------	--

If "Yes"

Day Surgery #1

**Reason**

**Year**

2002-2021,  
9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

**Name of hospital or doctor**

**Location of hospital or doctor**

City, State

**Have you had another day surgery?**

- ☐ No  
☐ Yes  
☐ Unknown

Day Surgery #2

**Reason**

**Year**

2002-2021,  
9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

**Name of hospital or doctor**

**Location of hospital or doctor**

City, State

**Have you had another day surgery?**

- ☐ No  
☐ Yes  
☐ Unknown

Day Surgery #3

**Reason**

**Year**

2002-2021,  
9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

**Name of hospital or doctor**

<b>Location of hospital or doctor</b>	<input style="width: 90%;" type="text"/> <small>City, State</small>
<b>Have you had another day surgery?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>Day Surgery #4</b>	
<b>Reason</b>	<input style="width: 90%;" type="text"/>
<b>Year</b>	<input style="width: 90%;" type="text"/> <small>2002-2021, 9999 = Unknown</small>
<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input style="width: 90%;" type="text"/>
<b>Name of hospital or doctor</b>	<input style="width: 90%;" type="text"/>
<b>Location of hospital or doctor</b>	<input style="width: 90%;" type="text"/> <small>City, State</small>
<b>If participant has had more than 4 day surgeries, provide details in "Additional Comments" below.</b>	
<b>Major illness with visit to doctor?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>If "Yes"</b>	
<b>Major Illness #1</b>	
<b>Reason</b>	<input style="width: 90%;" type="text"/>
<b>Year</b>	<input style="width: 90%;" type="text"/> <small>2002-2021, 9999 = Unknown</small>
<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input style="width: 90%;" type="text"/>
<b>Name of doctor</b>	<input style="width: 90%;" type="text"/>
<b>Location of doctor</b>	<input style="width: 90%;" type="text"/> <small>City, State</small>
<b>Have you had another major illness with visit to doctor?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Major Illness #2

**Reason**

**Year**

2002-2021,  
9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

**Name of doctor**

**Location of doctor**

City, State

**Have you had another major illness with visit to doctor?**

- ☐ No  
☐ Yes  
☐ Unknown

Major Illness #3

**Reason**

**Year**

2002-2021,  
9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

**Name of doctor**

**Location of doctor**

City, State

**Have you had another major illness with visit to doctor?**

- ☐ No  
☐ Yes  
☐ Unknown

Major Illness #4

**Reason**

**Year**

2002-2021,  
9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

**Name of doctor**

Location of doctor

City, State

If participant has had more than 4 major illnesses, provide details in "Additional Comments" below.

Checkup or office visit with doctor or other health care provider?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

Checkup or office visit #1

Reason

Year

2002-2021,  
9999 = Unknown

DATE details

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of doctor

Location of doctor

City, State

Have you had another checkup or office visit with doctor or other health care provider?

- ☐ No  
☐ Yes  
☐ Unknown

Checkup or office visit #2

Reason

Year

2002-2021,  
9999 = Unknown

DATE details

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of doctor

Location of doctor

City, State

Have you had another checkup or office visit with doctor or other health care provider?

- ☐ No  
☐ Yes  
☐ Unknown

---

Checkup or office visit #3

**Reason**

**Year**

2002-2021,  
9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

**Name of doctor**

**Location of doctor**

City, State

**Have you had another checkup or office visit with doctor or other health care provider?**

- ☐ No  
☐ Yes  
☐ Unknown

---

Checkup or office visit #4

**Reason**

**Year**

2002-2021,  
9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

**Name of doctor**

**Location of doctor**

City, State

**If participant has had more than 4 checkups or office visits, provide details in "Additional Comments" below.**

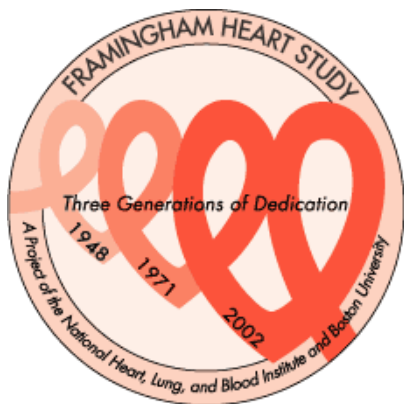
---

**Additional Comments**

---

**Medical Encounters**





# Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

## Aspirin, Diagnoses and Treatment Questions

### Aspirin

Do you take aspirin REGULARLY?

- ☐ No
- ☐ Yes
- ☐ Unknown

If "Yes"

How many aspirin?

999=Unknown

How often do you take ([numaspirin]) aspirin?

- ☐ Day
- ☐ Week
- ☐ Month
- ☐ Year
- ☐ Unknown

Usual dose of aspirin (mg)?

- ☐ 81 mg - Baby
- ☐ 160 mg - Half
- ☐ 250 mg - e.g. Excedrin
- ☐ 325 mg - Usual
- ☐ 500 mg - Extra strength
- ☐ Other
- ☐ Unknown

If dose of aspirin is "Other"

Aspirin dose in mg

## Diagnoses and Treatment Questions

### High Blood Pressure or Hypertension

Have you been TOLD by your doctor you have high blood pressure or hypertension?

- ☐ No
- ☐ Yes
- ☐ Unknown

Are you CURRENTLY TAKING MEDICATION for high blood pressure or hypertension?

- ☐ No
- ☐ Yes
- ☐ Unknown

### High Blood Cholesterol or High Triglycerides

Have you been TOLD by your doctor you have high blood cholesterol or high triglycerides?

- ☐ No
- ☐ Yes
- ☐ Unknown

Are you CURRENTLY TAKING MEDICATION for high blood cholesterol or high triglycerides?

- ☐ No
- ☐ Yes
- ☐ Unknown

### High Blood Sugar or Diabetes

Have you been TOLD by your doctor you have high blood sugar or diabetes?

- ☐ No
- ☐ Yes
- ☐ Unknown

Are you CURRENTLY TAKING MEDICATION for high blood sugar or diabetes?

- ☐ No
- ☐ Yes
- ☐ Unknown

### Cardiovascular Disease

---

Are you CURRENTLY TAKING medication for cardiovascular disease?

(for example angina/chest pain, heart failure, atrial fibrillation/heart rhythm abnormality, stroke, leg pain when walking, peripheral artery disease)

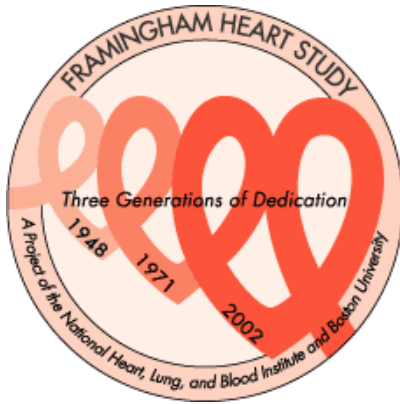
- ☐ No
- ☐ Yes
- ☐ Unknown

---

### Additional Comments

Aspirin, Diagnoses and Treatment Questions





## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### Medications

---

#### As Directed by Physician or HCP

---

In the PAST MONTH have you taken any prescription or non-prescription medication AS DIRECTED by physician or other health care provider?

- ☐ No  
☐ Yes  
☐ Unknown

---

If "Yes"

Medication bag with medications brought to exam?

- ☐ No  
☐ Yes

---

**NOTE: For ASPIRIN ONLY - Do not code aspirin on this page. CODE ON PRIOR PAGE M03**

---

Medication name #1

Medication name #2

**Medication name #3**

**Medication name #4**

**Medication name #5**

**Medication name #6**

**Medication name #7**

**Medication name #8**

**Medication name #9**

**Medication name #10**

**Medication name #11**

**Medication name #12**

**Medication name #13**

**Medication name #14**

**Medication name #15**

**Medication name #16**

**Medication name #17**

**Medication name #18**

---

**Medication name #19**

---

**Medication name #20**

---

**Are there any medications that you could not find on the drop down list?**

- ☐ No  
☐ Yes

---

**Medication name #1 - not in drop down list**

---

**Medication name #2 - not in drop down list**

---

**Medication name #3 - not in drop down list**

---

**Medication name #4 - not in drop down list**

---

**Medication name #5 - not in drop down list**

---

**Medication name #6 - not in drop down list**

---

**Medication name #7 - not in drop down list**

---

**Medication name #8 - not in drop down list**

---

**Medication name #9 - not in drop down list**

---

**Medication name #10 - not in drop down list**

---

**Medication name #11 - not in drop down list**

---

**Medication name #12 - not in drop down list**

---

**Medication name #13 - not in drop down list**

---

Medication name #14 - not in drop down list

---

Medication name #15 - not in drop down list

---

Medication name #16 - not in drop down list

---

Medication name #17 - not in drop down list

---

Medication name #18 - not in drop down list

---

Medication name #19 - not in drop down list

---

Medication name #20 - not in drop down list

---

### Over the Counter Products (OTC)

---

Are you taking over the counter products that are NOT DIRECTED by a physician or health care provider (i.e. vitamins, supplements, plant extracts, alternatives)?

- ☐ No  
☐ Yes  
☐ Unknown

---

Please answer all over the counter questions below:

---

	No	Yes
Vitamins	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

---

### Vaccinations

---

Have you received an influenza vaccine (aka "flu shot") within the last year?

- ☐ No  
☐ Yes  
☐ Maybe  
☐ Unknown

---

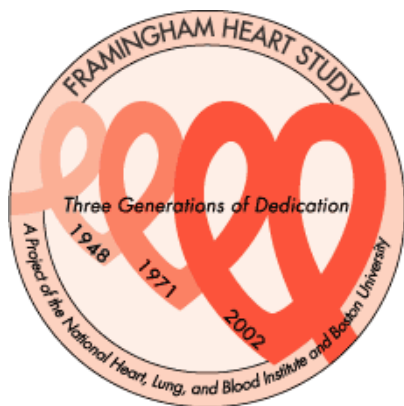
Have you ever received a pneumovaccine?

- ☐ No  
☐ Yes  
☐ Maybe  
☐ Unknown
-

**Additional Comments**

**Medications**





## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### Female Reproductive History - Pregnancy

---

**Participant is male. Select "Save and go to Next Form".**

---

Check here to confirm study participant is female.

☐ Yes, female

---

#### Pregnancy

---

Since your last exam ([lastexamdate]) have you taken or used birth control pills, shots, or hormone implants for birth control or medical indications (not post menopausal hormone replacement)?

- ☐ No
- ☐ Yes, now
- ☐ Yes, not now
- ☐ Unknown

---

Have you ever tried to become pregnant for a year or more without becoming pregnant?

- ☐ No
- ☐ Yes
- ☐ Unknown

<b>Have you ever used infertility treatment?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>Have you been pregnant since your last exam ([lastexamdate])?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>If "Yes"</b>	
<b>Number of pregnancies?</b>	<input type="radio"/> One pregnancy <input type="radio"/> Two pregnancies <input type="radio"/> Three pregnancies <input type="radio"/> Four pregnancies <input type="radio"/> Five pregnancies <input type="radio"/> Six pregnancies <input type="radio"/> Seven pregnancies
<b>During any of these pregnancies, were you told you had high blood pressure or hypertension?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>During any of these pregnancies, were you told you had eclampsia, pre-eclampsia (toxemia)?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>During any of these pregnancies, were you told you had high blood sugar or diabetes?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>Have you had any live births since your last exam ([lastexamdate])?</b>	<input type="radio"/> No <input type="radio"/> Yes
<b>If "Yes"</b>	
<b>Number of live births since your last exam ([lastexamdate])</b>	<input type="radio"/> One baby <input type="radio"/> Two babies <input type="radio"/> Three babies <input type="radio"/> Four babies

## Questions about babies (born since last exam)

Now, I would like to ask you about how much each of your children (born after last exam) weighed at birth and whether you breastfed.

### Baby #1

Full term?

- ☐ Less than 37 weeks
- ☐ 37 weeks or more
- ☐ Unknown

Birth weight - (pounds)

99 = Unknown

Birth weight - (ounces)

99 = Unknown

Did you breast feed?  
(include expressed breast milk)

- ☐ No
- ☐ Yes
- ☐ Unknown

If "Yes"

How long?

- ☐ Less than 6 weeks
- ☐ 6 to 11 weeks
- ☐ 3 to 6 months
- ☐ More than 6 months
- ☐ Unknown

### Baby #2

Full term?

- ☐ Less than 37 weeks
- ☐ 37 weeks or more
- ☐ Unknown

Birth weight - (pounds)

99 = Unknown

Birth weight - (ounces)

99 = Unknown

Did you breast feed?  
(include expressed breast milk)

- ☐ No
- ☐ Yes
- ☐ Unknown

<b>If "Yes"</b>	
<b>How long?</b>	<input type="radio"/> Less than 6 weeks <input type="radio"/> 6 to 11 weeks <input type="radio"/> 3 to 6 months <input type="radio"/> More than 6 months <input type="radio"/> Unknown
<b>Baby #3</b>	
<b>Full term?</b>	<input type="radio"/> Less than 37 weeks <input type="radio"/> 37 weeks or more <input type="radio"/> Unknown
<b>Birth weight - (pounds)</b>	<input type="text"/> <small>99 = Unknown</small>
<b>Birth weight - (ounces)</b>	<input type="text"/> <small>99 = Unknown</small>
<b>Did you breast feed? (include expressed breast milk)</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>If "Yes"</b>	
<b>How long?</b>	<input type="radio"/> Less than 6 weeks <input type="radio"/> 6 to 11 weeks <input type="radio"/> 3 to 6 months <input type="radio"/> More than 6 months <input type="radio"/> Unknown
<b>Baby #4</b>	
<b>Full term?</b>	<input type="radio"/> Less than 37 weeks <input type="radio"/> 37 weeks or more <input type="radio"/> Unknown
<b>Birth weight - (pounds)</b>	<input type="text"/> <small>99 = Unknown</small>
<b>Birth weight - (ounces)</b>	<input type="text"/> <small>99 = Unknown</small>

---

**Did you breast feed?  
(include expressed breast milk)**

- ☐ No
- ☐ Yes
- ☐ Unknown

---

**If "Yes"**

---

**How long?**

- ☐ Less than 6 weeks
- ☐ 6 to 11 weeks
- ☐ 3 to 6 months
- ☐ More than 6 months
- ☐ Unknown

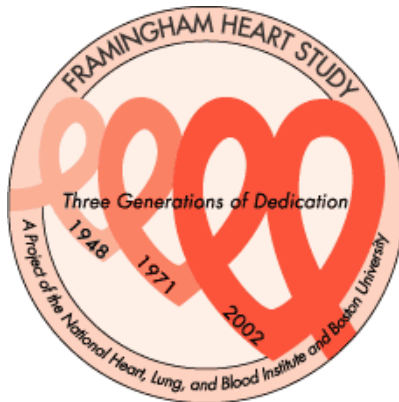
---

### **Additional Comments**

---

**Female Reproductive History - Pregnancy**





## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### Female Reproduction History - Menopause and Surgery

**Participant is male. Select "Save and go to Next Form".**

Check here to confirm study participant is female.

☐ Yes, female


#### Menopause

What is the best way to describe your periods?

(Check the BEST answer)

- ☐ Not stopped - **answer D and E below**
- ☐ Periods stopped due to pregnancy, breast feeding, or hormonal contraceptive (for example: depo-provera, progestin releasing IUD, extended release birth control pill) - **answer D and E below**
- ☐ 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 - **answer A, D and E below**
- ☐ Periods stopped for less than 1 year (perimenopausal) - **answer B, D, E, F, G and H below**
- ☐ Periods stopped for 1 year or more - **answer F, G and H below**
- ☐ Periods stopped, but now have periods induced by hormones - **answer C, F, G and H below**

**If question is not applicable write "N/A"**

<b>A.) Write in CAUSE why periods stopped</b>	<input type="text"/>
<b>B.) NUMBER OF MONTHS since last period</b>	<input type="text"/> 99=Unknown
<b>C.) NUMBER OF MONTHS periods stopped before hormones started</b>	<input type="text"/> 99 = Unknown
<b>D.) WHEN was the first day of your last menstrual period?</b> (If first day of last menstrual period is unknown, enter 1/1/1900)	<input type="text"/>  Today M-D-Y 1/1/1900 = Unknown
<b>E.) HOW MANY periods have you had in past 12 months?</b>	<input type="text"/> 99=Unknown
<b>F.) AGE when periods stopped</b> (If periods now induced by hormones, code age when periods naturally stopped. If perimenopausal, code age when periods stopped or became irregular.)	<input type="text"/> 99=Unknown
<b>G.) Was your menopause natural or the result of surgery, chemotherapy, or radiation?</b> (If periods stopped for less than a year choose best answer.)	<p><input type="radio"/> Natural</p> <p><input type="radio"/> Surgical</p> <p><input type="radio"/> Chemo or radiation</p> <p><input type="radio"/> Other</p> <p><input type="radio"/> Unknown</p>
<b>H.) Have you since your last exam ([lastexamdate]) taken HORMONE REPLACEMENT THERAPY (estrogen or progesterone) or a selective estrogen receptor modulator (such as <u>evista</u> or <u>raloxifene</u>)?</b>	<p><input type="radio"/> No</p> <p><input type="radio"/> Yes, now</p> <p><input type="radio"/> Yes, not now</p> <p><input type="radio"/> Unknown</p>

### Surgery History

<b>Since your last exam ([lastexamdate]) have you had a hysterectomy (uterus or womb removed)?</b>	<p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> Unknown</p>
<b>If "Yes"</b>	
<b>Age at hysterectomy?</b>	<input type="text"/> 99=Unknown
<b>Date of hysterectomy - Year</b>	<input type="text"/> 2002-2021, 9999 = Unknown
<b>Date of hysterectomy - Month</b>	<input type="text"/> 1-12, 99 = Unknown

---

Since your last exam ([lastexamdate]) have you had an operation to remove one or both of your ovaries?

- ☐ No
- ☐ Yes
- ☐ Unknown

---

If "Yes"

Age when ovaries removed?

(If more than one surgery, use age at last surgery.)

99=Unknown

Number of ovaries removed?

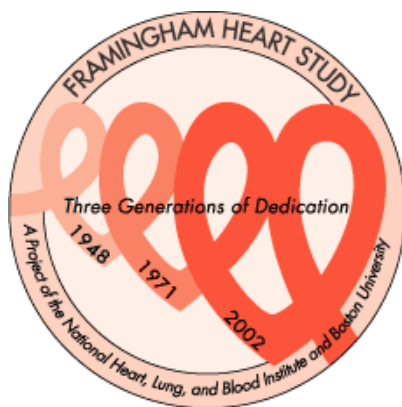
- ☐ One ovary
- ☐ Two ovaries
- ☐ Part of an ovary
- ☐ Unknown number of ovaries

---

### Additional Comments

Female Reproduction History - Menopause and Surgery





## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### Smoking

---

#### Cigarettes

---

Since your last exam ([lastexamdate]) have you smoked cigarettes regularly?

- ☐ No
- ☐ Yes
- ☐ Unknown

---

If "Yes"

Have you smoked cigarettes regularly in the LAST YEAR?

- ☐ No or less than 1 cigarette a day per year
- ☐ Yes
- ☐ Unknown

---

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

- ☐ No
- ☐ Yes
- ☐ Unknown

How many cigarettes do you smoke per day now?

99 = Unknown

*Questions below refer to "whole lifetime"*

On the average of the entire time you smoked, how many cigarettes did you smoke per day?

99 = Unknown

How old were you when you first started regular cigarette smoking?

99 = Unknown

If you have stopped smoking cigarettes completely, how old were you when you stopped?

00 = Not stopped,  
99 = Unknown

When you were smoking, did you ever stop smoking for more than 6 months?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

For how many years in total did you stop smoking cigarettes?

# of years,  
1 = 6 months - 12 months,  
99 = Unknown

## Pipes or Cigars

Since your last exam ([lastexamdate]) have you regularly smoked a pipe or cigar?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

Do you smoke a pipe or cigar now?

- ☐ No  
☐ Yes  
☐ Unknown

## E-cigarettes

**E-cigarettes are battery-powered and produce vapor instead of smoke.**

Have you ever tried an e-cigarette?

- ☐ No  
☐ Yes  
☐ Unknown

---

If "Yes"

Have you ever been a regular user of e-cigarettes?  
(at least once per week)

- ☐ No
- ☐ Yes
- ☐ Unknown

---

If "Yes"

How long did you use e-cigarettes? - months

999 = Unknown

How many days per week, on average, did you  
use e-cigarettes while you were a regular user?

# of days per week,  
1 = 1 day or less per week,  
9 = Unknown

In the past 5 days, including today, on how many  
days did you smoke an e-cigarette?

- ☐ 0 days
- ☐ 1 day
- ☐ 2 days
- ☐ 3 days
- ☐ 4 days
- ☐ 5 days
- ☐ Refused to answer
- ☐ Don't know

---

### Additional Comments

Smoking





## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### Alcohol Consumption

Now I will ask you questions regarding your alcohol use.

Do you drink beer at least once a month?  
(serving 12 oz. bottle, glass, can)

- ☐ No
- ☐ Yes
- ☐ Unknown

If "Yes"

Do you drink beer at least once week?

- ☐ No
- ☐ Yes
- ☐ Unknown

If "Yes"

Number of beers per week

999 = Unknown

If "No"

Number of beers per month

999 = Unknown

Do you drink wine at least once a month?  
(serving red or white, 4oz. glass)

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

Do you drink wine at least once a week?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

Number of glasses of wine per week

999 = Unknown

If "No"

Number of glasses of wine per month

999 = Unknown

Do you drink liquor or spirits at least once a month?  
(serving 1 oz. cocktail or highball)

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

Do you drink liquor or spirits at least once per week?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

Number of liquor or spirit drinks per week

999 = Unknown

If "No"

Number of liquor or spirit drinks per month

999 = Unknown

At what age did you stop drinking alcohol?

00 = IF NOT STOPPED  
888 = NEVER DRINKER

00 = If not stopped,  
888 = Never drinker,  
999 = Unknown

Over the past year, on average, on how many days per week did you drink an alcoholic beverage of any type?

0 = No days,  
1 = 1 day or less,  
9 = Unknown

Over the past year, on a typical day when you drink, how many drinks do you have?

0 = No drinks,  
1 = 1 or less,  
99 = Unknown

What was the maximum number of drinks you had in a 24 hour period during the past month?

0 = No drinks,  
1 = 1 or less,  
99 = Unknown

Since your last exam has there been a time when you drank 5 or more alcoholic drinks of any kind almost daily?

- ☐ No  
☐ Yes  
☐ Unknown

**Examiner Opinion:**

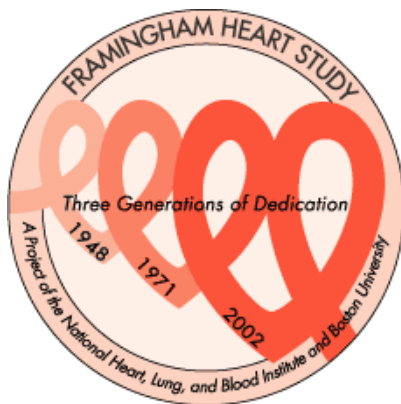
Over the past year, does participant report drinking less than one alcoholic drink of any type per month?  
(include current non-drinkers)

- ☐ Yes

## Additional Comments

### Alcohol Consumption





# Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

## Respiratory Symptoms

Cough	
<p><b>Do you usually have a cough?</b> - Exclude clearing of the throat</p>	<p> <input type="radio"/> No  <input type="radio"/> Yes  <input type="radio"/> Unknown </p>
<a href="#">reset</a>	
<p><b>Do you usually have a cough at all on getting up or first thing in the morning?</b></p>	<p> <input type="radio"/> No  <input type="radio"/> Yes  <input type="radio"/> Unknown </p>
<a href="#">reset</a>	
<p><b>If "Yes" to either of the two questions directly above</b></p>	
<p><b>Do you cough like this on most days for three consecutive months or more during the past year?</b></p>	<p> <input type="radio"/> No  <input type="radio"/> Yes  <input type="radio"/> Unknown </p>

How many years have you had this cough?

Number of years,  
1 = 1 year or less,  
99 = Unknown

## Phlegm

Do you usually bring up phlegm from your chest?

- ☐ No  
☐ Yes  
☐ Unknown

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

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes" to either of 2 questions directly above

Do you bring up phlegm from your chest on most days for three consecutive months or more during the year?

- ☐ No  
☐ Yes  
☐ Unknown

How many years have you had trouble with phlegm?

Number of years,  
1 = 1 year or less,  
99 = Unknown

## Wheeze

In the past 12 months . . .

Have you had wheezing or whistling in your chest at any time?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

How often have you had this wheezing or whistling?

- ☐ MOST days or nights  
☐ A few days or nights a WEEK  
☐ A few days or nights a MONTH  
☐ A few days or nights a YEAR or less  
☐ Unknown

Have you had this wheezing or whistling in the chest when you had a cold?

- ☐ No  
☐ Yes  
☐ Unknown

---

**Have you had this wheezing or whistling in the chest apart from colds?**

- ☐ No
- ☐ Yes
- ☐ Unknown

---

**Have you had an attack of wheezing or whistling in the chest that made you feel short of breath?**

- ☐ No
- ☐ Yes
- ☐ Unknown

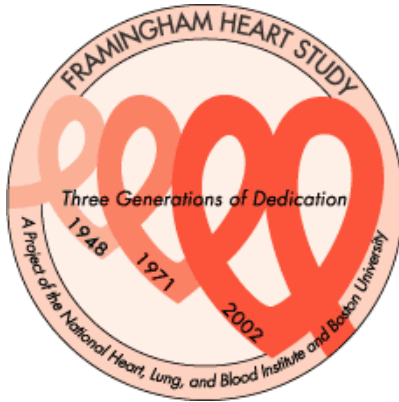
---

### **Additional Comments**

---

#### **Respiratory Symptoms**





## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### Sleep Apnea and CHF Opinion

#### Sleep Related Symptoms (days/ nights)

**In the past 12 months...**

**On average how many nights a week did you snore?**

- ☐ Never
- ☐ Rarely (1-2 nights/week)
- ☐ Occasionally (3-4 nights/week)
- ☐ Frequently (5 or more nights/week)
- ☐ I don't know
- ☐ Unknown

[reset](#)

---

**On average, how many nights a week do you snort, gasp, or stop breathing while you are asleep?**

- ☐ Never
- ☐ Rarely (1-2 nights/week)
- ☐ Occasionally (3-4 nights/week)
- ☐ Frequently (5 or more nights/week)
- ☐ I don't know
- ☐ Unknown

---

**On average, how many days a week have you had excessive (too much) daytime sleepiness?**

- ☐ Never
- ☐ Rarely (1-2 days/week)
- ☐ Occasionally (3-4 days/week)
- ☐ Frequently (5 or more days/week)
- ☐ I don't know
- ☐ Unknown

---

### Nocturnal Chest Symptoms

---

Since your last exam ([lastexamdate]) . . .

---

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

- ☐ No
- ☐ Yes
- ☐ Unknown

---

**Have you been awakened by coughing?**

- ☐ No
- ☐ Yes
- ☐ Unknown

---

### Shortness of Breath

---

Since your last exam ([lastexamdate]) . . .

---

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

- ☐ No
- ☐ Yes
- ☐ Unknown

---

**If "Yes"**

---

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

- ☐ No
- ☐ Yes
- ☐ Unknown

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

- ☐ No  
☐ Yes  
☐ Unknown

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

- ☐ No  
☐ Yes  
☐ Unknown

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

- ☐ No  
☐ Yes  
☐ Unknown

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

- ☐ No  
☐ Yes  
☐ Unknown

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

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

Have medical encounter details been entered on M01 Medical Encounters?

- ☐ No  
☐ Yes

If "No"

Name of doctor

Location of doctor

City, state

Date of visit - year

9999 = Unknown

DATE details

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Have you been hospitalized or visited the E.R. for heart failure?

- ☐ No  
☐ Yes  
☐ Unknown

---

**If "Yes"**

---

**Have medical encounter details been entered on M01 Medical Encounters?**

- ☐ No  
☐ Yes

---

**If "No"**

---

**Name of hospital**

**Location of hospital**

City, state

**Date of hospitalization - year**

9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

---

**CHF First Examiner Opinion**

---

**First Examiner believes CHF**

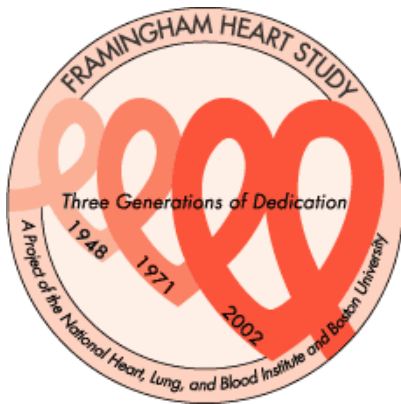
- ☐ No  
☐ Yes  
☐ Maybe  
☐ Unknown

---

**Additional Comments**

---

**Sleep Apnea and CHF Opinion**



## Framingham Heart Study

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### Blood Pressure 1st MD Reading

**BP cuff size**

- ☐ Pediatric
- ☐ Regular adult
- ☐ Large adult
- ☐ Thigh
- ☐ Unknown

**Protocol modification**

- ☐ No
- ☐ Yes
- ☐ Unknown

**If "Yes"**

**Comments for protocol modification**

---

**Systolic (to nearest 2 mmHg)**

999 = Unknown

---

**Diastolic (to nearest 2 mmHg)**

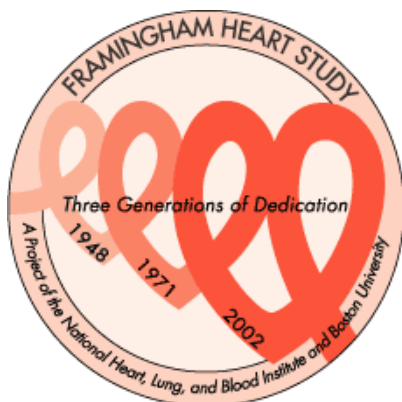
999 = Unknown

---

### **Additional Comments**

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**Blood Pressure 1st MD Reading**



## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### Chest Discomfort and CHD Opinion

---

Since you last provided medical information ([lastmedinfodate])...

---

Have you experienced any CHEST DISCOMFORT?

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

---

If "Yes" or "Maybe"

---

***In addition to answering the questions, provide narrative comments in box below.***

---

Chest discomfort with exertion or excitement

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

**Chest discomfort when quiet or resting**

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

## Chest Discomfort Characteristics

**Date of onset - year**

2002-2021,  
9999 = Unknown

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

**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**

- ☐ No
- ☐ Central sternum and upper chest
- ☐ Left upper quadrant
- ☐ Left lower ribcage
- ☐ Right chest
- ☐ Other
- ☐ Combination
- ☐ Unknown

**Radiation**

- ☐ No
- ☐ Left shoulder or left arm
- ☐ Neck
- ☐ Right shoulder or right arm
- ☐ Back
- ☐ Abdomen
- ☐ Other
- ☐ Combination
- ☐ Unknown

<b>Number of episodes of chest pain in past month</b>	<input style="width: 90%;" type="text"/> <small>999 = Unknown</small>
<b>Number of episodes of chest pain in past year</b>	<input style="width: 90%;" type="text"/> <small>999 = Unknown</small>
<b>Type</b>	<input type="radio"/> Pressure, heavy, vise <input type="radio"/> Sharp <input type="radio"/> Dull <input type="radio"/> Other <input type="radio"/> Unknown

	No	Yes	Not tried	Unknown
<b>Relief by nitroglycerin in &lt; 15 minutes</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Relief by rest in &lt; 15 minutes</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Relief spontaneously in &lt; 15 minutes</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Relief by other cause in &lt; 15 minutes</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Since you last provided medical information ([lastmedinfo date])...**

<b>Have you been told by a doctor you had a heart attack, myocardial infarction or angina?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Unknown
--	---

**If "Yes" or "Maybe"**

<b>Have medical encounter details been entered on M01 Medical Encounters?</b>	<input type="radio"/> No <input type="radio"/> Yes
---	---

**If "No"**

<b>Name of doctor</b>	<input style="width: 90%;" type="text"/>
<b>Location of doctor</b>	<input style="width: 90%;" type="text"/> <small>City, State</small>
<b>Date of visit - year</b>	<input style="width: 90%;" type="text"/> <small>2002-2021, 9999 = Unknown</small>
<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input style="width: 90%;" type="text"/>

Since you last provided medical information ([lastmedinfo date])...

Have you been to a hospital or visited the ER for a heart attack, myocardial infarction or angina?

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

Have medical encounter details been entered on M01 Medical Encounters?

- ☐ No
- ☐ Yes

If "No"

Name of hospital

Location of hospital

City, State

Date - year

2002-2021,  
9999 = Unknown

DATE details

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

### CHD First Examiner Opinions

Angina pectoris

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

Angina pectoris since revascularization procedure?

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

Coronary insufficiency

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

---

**Myocardial infarct**

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

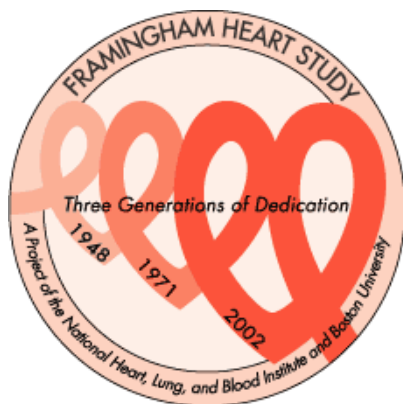
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**Additional Comments**

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**Chest Discomfort and CHD Opinion**





# Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

## Atrial Fibrillation, Syncope & Syncope Opinion

### Atrial Fibrillation

Since your last provided medical information ([lastmedinfodate]) . . .

Have you been told you have or have had atrial fibrillation (or atrial flutter)?

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

Year of first episode since [lastmedinfodate]

2002-2021,  
9999 = Unknown

DATE details of first episode since [lastmedinfodate]  
(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Hospitalized, ER or saw M.D.

- ☐ No
- ☐ Hospitalized or ER
- ☐ Saw M.D.
- ☐ Unknown

If "Hospitalized or ER" or "Saw M.D."

Have medical encounter details been entered on M01 Medical Encounters?

- ☐ No
- ☐ Yes

If "No"

Name of hospital

Location of hospital

City, State

Name of doctor

Location of doctor

City, State

Year

2002-2021,  
9999 = Unknown

DATE details

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

## Syncope

Since your last exam ([lastexamdate]) . . .

Have you fainted or lost consciousness?

(If event immediately preceded by head injury or accident, code as "No")

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

Year of first episode since [lastexamdate]

2002-2021,  
9999 = Unknown

DATE details

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Number of episodes in the past two years

999=Unknown

Usual duration of loss of consciousness - minutes

1=1 min or less  
999=Unknown

Did you have any injury caused by the event?

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

Hospitalized, ER or saw M.D. for fainting or loss of consciousness

- ☐ No
- ☐ Hospitalized or ER
- ☐ Saw M.D.
- ☐ Unknown

If "Hospitalized or ER" or "Saw M.D."

Have medical encounter details been entered on M01 Medical Encounters?

- ☐ No
- ☐ Yes

If "No"

Name of hospital

Location of hospital

City, State

Name of M.D.

Location of doctor

City, State

Year

2002-2021,  
9999 = Unknown

DATE details  
(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Have you had a head injury with loss of consciousness?

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

Have medical encounter details been entered on M01 Medical Encounters?

- ☐ No
- ☐ Yes

If "No"

Year

2002-2021,  
9999 = Unknown

<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input style="width: 90%;" type="text"/>
<b>Have you had a seizure?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Unknown
<b>If "Yes" or "Maybe"</b>	
<b>Year of most recent seizure since [lastmedinfodate]</b>	<input style="width: 90%;" type="text"/> <small>2002-2021, 9999 = Unknown</small>
<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input style="width: 90%;" type="text"/>
<b>Hospitalized, ER or saw M.D.</b>	<input type="radio"/> No <input type="radio"/> Hospitalized or ER <input type="radio"/> Saw M.D. <input type="radio"/> Unknown
<b>If "Hospitalized or ER" or "Saw M.D."</b>	
<b>Have medical encounter details been entered on M01 Medical Encounters?</b>	<input type="radio"/> No <input type="radio"/> Yes
<b>If "No"</b>	
<b>Name of hospital</b>	<input style="width: 90%;" type="text"/>
<b>Location of hospital</b>	<input style="width: 90%;" type="text"/> <small>City, State</small>
<b>Name of doctor</b>	<input style="width: 90%;" type="text"/>
<b>Location of doctor</b>	<input style="width: 90%;" type="text"/> <small>City, State</small>
<b>Year</b>	<input style="width: 90%;" type="text"/> <small>2002-2021, 9999 = Unknown</small>
<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input style="width: 90%;" type="text"/>
<b>Are you being treated for a seizure disorder?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Unknown

---

### Syncope First Examiner Opinion

---

**Syncope**

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Presyncope
- ☐ Unknown

---

**If "Yes" or "Maybe"**

---

**Cardiac syncope**

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

**Vasovagal syncope**

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

**Other syncope**

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

---

**Specify other syncope**

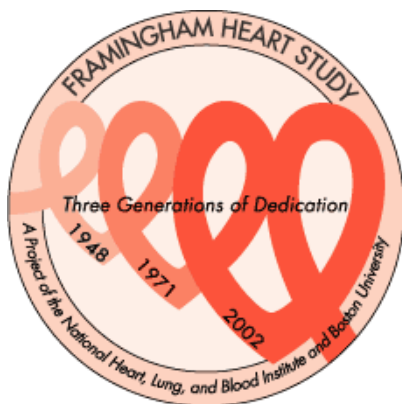
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### Additional Comments

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**Atrial Fibrillation, Syncope & Syncope Opinion**





# Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

## Cerebrovascular Disease and Opinion

### Cerebrovascular Disease

Since you last provided medical information ([lastmedinfodate]) have you had . . .

	No	Yes	Maybe	Unknown
Sudden muscular weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sudden speech difficulty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sudden visual defect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sudden double vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sudden loss of vision in one eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sudden numbness, tingling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If "Yes" or "Maybe"

Numbness and tingling is positional

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

HEAD CT scan OTHER THAN FOR THE FHS

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

Have medical encounter details been entered on M01 Medical Encounters?

- ☐ No
- ☐ Yes

If "No"

Name of facility

Location of facility

City, State

Date - year

2002-2021,  
9999 = Unknown

DATE details

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

HEAD MRI scan OTHER THAN FOR THE FHS

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

Have medical encounter details been entered on M01 Medical Encounters?

- ☐ No
- ☐ Yes

If "No"

Name of facility

Location of facility

City, State

<b>Date - year</b>	<input style="width: 100%;" type="text"/> <small>2002-2021, 9999 = Unknown</small>			
<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input style="width: 100%;" type="text"/>			
<b>Seen by neurologist</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Unknown			
<b>If "Yes" or "Maybe"</b>				
<b>Have medical encounter details been entered on M01 Medical Encounters?</b>	<input type="radio"/> No <input type="radio"/> Yes			
<b>If "No"</b>				
<b>Name of neurologist</b>	<input style="width: 100%;" type="text"/>			
<b>Location of neurologist</b>	<input style="width: 100%;" type="text"/> <small>City, State</small>			
<b>Date - year</b>	<input style="width: 100%;" type="text"/> <small>2002-2021, 9999 = Unknown</small>			
<b>DATE details</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input style="width: 100%;" type="text"/>			
	<b>No</b>	<b>Yes</b>	<b>Maybe</b>	<b>Unknown</b>
<b>Have you been told by a doctor you had a STROKE or TIA (transient ischemic attack, mini-stroke)?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Have you been told by a doctor you have PARKINSON'S disease?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Have you been told by a doctor you have MEMORY problems, DEMENTIA or ALZHEIMER'S disease?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>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?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Do you feel your memory is becoming WORSE?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Cerebrovascular Disease First Examiner Opinion

TIA or STROKE took place

☐ No  
☐ Yes  
☐ Maybe  
☐ Unknown

If "Yes" or "Maybe"

Date of TIA or STROKE - year

2002-2021,  
9999 = Unknown

DATE details

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Observed by

Total duration of TIA or STROKE = # days + # hours + # minutes

Duration - number of days

99 = Unknown

Duration - number of hours

0 - 23,  
99 = Unknown

Duration - number of minutes

0 - 59,  
99 = Unknown

Hospitalized or saw MD

- ☐ No  
☐ Hospitalized or ER  
☐ Saw MD  
☐ Unknown

If "Hospitalized or ER" or "Saw MD"

Have medical encounter details been entered on  
M01 Medical Encounters?

- ☐ No  
☐ Yes

If "No"

Name of hospital

Location of hospital

City, State

Name of doctor

Location of doctor

City, State

---

**Date - year**

2002-2021,  
9999 = Unknown

---

**DATE details**

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

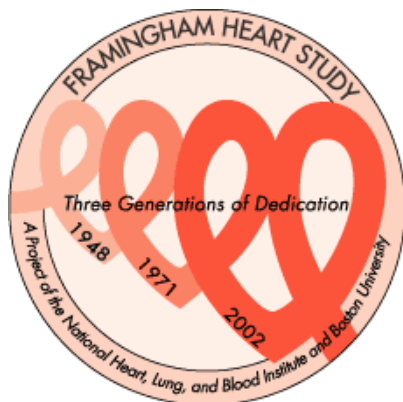
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### **Additional Comments**

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**Cerebrovascular Disease and Opinion**





## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### Venous and Peripheral Arterial Disease and Intermittent Claudication Opinion

---

#### Venous Disease

---

Since you last provided medical information ([lastmedinfodate]) have you had . . .

---

Deep vein thrombosis - DVT (blood clots in legs or arms)

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

---

Pulmonary embolus - PE (blood clot in lungs)

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

## Peripheral Arterial Disease

Since you last provided medical information ([lastmedinfodate]) . . .

Do you get discomfort in either leg on walking?

☐ No  
☐ Yes  
☐ Unknown

If "Yes"

Does this discomfort ever begin when you are standing still or sitting?

☐ No  
☐ Yes  
☐ Unknown

When walking at an ordinary pace on level ground, how many city blocks until symptoms develop?

(where 10 blocks = 1 mile)

0 = more than 98 blocks required to develop symptoms,  
1 = 1 block or less,  
99 = Unknown

## Claudication Symptoms

Discomfort while walking...

	No	Yes	Unknown
CALF - left	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CALF - right	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
NOT CALF - left lower extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
NOT CALF - right lower extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If "Yes" discomfort NOT CALF - left or right

Write in site of discomfort

Occurs with first steps (code worse leg)

☐ No  
☐ Yes  
☐ Unknown

Do you get the discomfort when you walk up a hill or hurry?

☐ No  
☐ Yes  
☐ Unknown

Does the discomfort ever disappear while you are still walking?

☐ No  
☐ Yes  
☐ Unknown

What do you do if you get discomfort when you are walking?

- ☐ Stop
- ☐ Slow down
- ☐ Continue at same pace
- ☐ Unknown

Time for discomfort to be relieved by stopping (minutes)

0 = No relief with stopping,  
999 = Unknown

Number of days per month of lower limb discomfort

1 = 1 day/month or less,  
99 = Unknown

Since your last exam ([lastexamdate]) have you been told by a doctor you have intermittent claudication or peripheral artery disease?

- ☐ No
- ☐ Yes
- ☐ Unknown

If "Yes"

Have medical encounter details been entered on M01 Medical Encounters?

- ☐ No
- ☐ Yes

If "No"

Name of doctor

Location of doctor

City, State

Date of visit - year

2002-2021,  
9999 = Unknown

DATE details

(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Since your last exam ([lastexamdate]) have you been told by a doctor you have spinal stenosis?

- ☐ No
- ☐ Yes
- ☐ Unknown

### Intermittent Claudication First Examiner Opinion

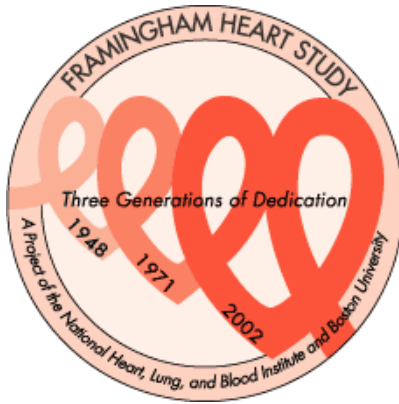
Intermittent claudication

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

---

**Additional Comments**

**Venous and Peripheral Arterial Disease and Intermittent Claudication Opinion**



## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### CVD Procedures

Since you last provided medical information ([lastmedinfodate])...

Did you have any of the following cardiovascular procedures?

(if procedure was repeated, code only FIRST and provide narrative)

Heart valvular surgery

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

YEAR - Heart valvular surgery

2002 - 2021,  
9999 = Unknown

Exercise stress test or other type of cardiac stress test	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Unknown
If "Yes" or "Maybe"	
YEAR - Exercise stress test	<input type="text"/> 2002 - 2021, 9999 = Unknown
Coronary arteriogram	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Unknown
If "Yes" or "Maybe"	
YEAR - Coronary arteriogram	<input type="text"/> 2002 - 2021, 9999 = Unknown
Coronary artery angioplasty or stent	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Unknown
If "Yes" or "Maybe"	
YEAR - Coronary artery angioplasty or stent	<input type="text"/> 2002 - 2021, 9999 = Unknown
Coronary bypass surgery	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Unknown
If "Yes" or "Maybe"	
YEAR - Coronary bypass surgery	<input type="text"/> 2002 - 2021, 9999 = Unknown
Permanent pacemaker insertion	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Unknown

If "Yes" or "Maybe"

YEAR - Permanent pacemaker insertion

2002 - 2021,  
9999 = Unknown

Carotid artery surgery or stent

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

YEAR - Carotid artery surgery or stent

2002 - 2021,  
9999 = Unknown

Thoracic aorta surgery

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

YEAR - Thoracic aorta surgery

2002 - 2021,  
9999 = Unknown

Abdominal aorta surgery

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

YEAR - Abdominal aorta surgery

2002 - 2021,  
9999 = Unknown

Femoral or lower extremity surgery

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

YEAR - Femoral or lower extremity surgery

2002 - 2021,  
9999 = Unknown

**Lower extremity amputation**

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

**If "Yes" or "Maybe"**

**YEAR - Lower extremity amputation**

2002 - 2021,  
9999 = Unknown

**Other cardiovascular procedure (specify below)**

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

**If "Yes" or "Maybe"**

**YEAR - Other cardiovascular procedure**

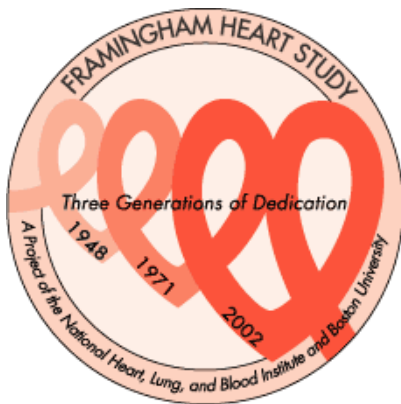
2002 - 2021,  
9999 = Unknown

**Specify other cardiovascular procedure**

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

## **Additional Comments**

**CVD Procedures**



## Framingham Heart Study

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### Blood Pressure 2nd MD Reading

**BP cuff size**

- ☐ Pediatric
- ☐ Regular adult
- ☐ Large adult
- ☐ Thigh
- ☐ Unknown

**Protocol modification**

- ☐ No
- ☐ Yes
- ☐ Unknown

**If "Yes"**

**Comments for protocol modification**

---

**Systolic (to nearest 2 mmHg)**

---

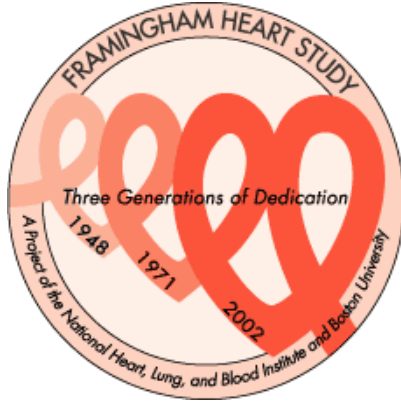
**Diastolic (to nearest 2 mmHg)**

---

**Additional Comments**

---

**Blood Pressure 2nd MD Reading**



# Framingham Heart Study

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## Cancer

Since your last provided medical information  
([lastmedinfo date]) have you had a cancer or tumor?

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

Cancer or tumor - #1

- ☐ Bladder
- ☐ Brain
- ☐ Breast
- ☐ Cervix/Uteru
- ☐ Colon/Rectum
- ☐ Esophagus
- ☐ Kidney
- ☐ Larynx
- ☐ Leukemia

- ☐ Lymphoma
- ☐ Ovary
- ☐ Pancreas
- ☐ Prostate
- ☐ Skin
- ☐ Stomach
- ☐ Thyroid
- ☐ Trachea/Bronchus/Lung
- ☐ Other

Cancer or tumor site for "Other" - #1 ([cancersite1])

Diagnosis - #1 ([cancersite1])

- ☐ Cancer
- ☐ Maybe cancer
- ☐ Benign

Have medical encounter details been entered on M01  
Medical Encounters - #1 ([cancersite1])

- ☐ No
- ☐ Yes

If "No"

Year first diagnosed - #1 ([cancersite1])

2002-2021,  
9999 = Unknown

DATE details - #1 ([cancersite1])  
(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of MD - #1 ([cancersite1])

Location of MD - #1 ([cancersite1])

City, State

Was a diagnostic biopsy done at a different  
location? - #1 ([cancersite1])

- ☐ No
- ☐ Yes

If "Yes"

Year of biopsy - #1 ([cancersite1])

2002-2021,  
9999 = Unknown

DATE details for biopsy - #1 ([cancersite1])  
(e.g. 10/2, April, Summer, August-Nov., Unknown etc)

Name of MD for biopsy - #1 ([cancersite1])

Location of biopsy - #1 ([cancersite1])

City, State

<p><b>Have you had a second cancer or tumor?</b></p>	<p> <input type="radio"/> No  <input type="radio"/> Yes  <input type="radio"/> Maybe  <input type="radio"/> Unknown         </p>
<p><b>If "Yes" or "Maybe"</b></p>	
<p>Cancer or tumor - #2</p>	<p> <input type="radio"/> Bladder  <input type="radio"/> Brain  <input type="radio"/> Breast  <input type="radio"/> Cervix/Uteru  <input type="radio"/> Colon/Rectum  <input type="radio"/> Esophagus  <input type="radio"/> Kidney  <input type="radio"/> Larynx  <input type="radio"/> Leukemia  <input type="radio"/> Lymphoma  <input type="radio"/> Ovary  <input type="radio"/> Pancreas  <input type="radio"/> Prostate  <input type="radio"/> Skin  <input type="radio"/> Stomach  <input type="radio"/> Thyroid  <input type="radio"/> Trachea/Bronchus/Lung  <input type="radio"/> Other         </p>
<p><b>Cancer or tumor site for "Other" - #2 ([cancersite2])</b></p>	<input type="text"/>
<p><b>Diagnosis - #2 ([cancersite2])</b></p>	<p> <input type="radio"/> Cancer  <input type="radio"/> Maybe cancer  <input type="radio"/> Benign         </p>
<p><b>Have medical encounter details been entered on M01 Medical Encounters - #2 ([cancersite2])</b></p>	<p> <input type="radio"/> No  <input type="radio"/> Yes         </p>
<p><b>If "No"</b></p>	
<p><b>Year first diagnosed - #2 ([cancersite2])</b></p>	<input type="text"/> <small>2002-2021, 9999 = Unknown</small>
<p><b>DATE details - #2 ([cancersite2])</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)</p>	<input type="text"/>
<p><b>Name of MD - #2 ([cancersite2])</b></p>	<input type="text"/>

<b>Location of MD - #2 ([cancersite2])</b>	<input type="text"/>
	City, State
<b>Was a diagnostic biopsy done at a different location? - #2 ([cancersite2])</b>	<input type="radio"/> No <input type="radio"/> Yes
<b>If "Yes"</b>	
<b>Year of biopsy - #2 ([cancersite2])</b>	<input type="text"/>
	2002-2021, 9999 = Unknown
<b>DATE details for biopsy - #2 ([cancersite2])</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc)	<input type="text"/>
<b>Name of MD for biopsy - #2 ([cancersite2])</b>	<input type="text"/>
<b>Location of biopsy - #2 ([cancersite2])</b>	<input type="text"/>
	City, State
<b>Have you had a third cancer or tumor?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Unknown
<b>If "Yes" or "Maybe"</b>	
Cancer or tumor - #3	<input type="radio"/> Bladder <input type="radio"/> Brain <input type="radio"/> Breast <input type="radio"/> Cervix/Uteru <input type="radio"/> Colon/Rectum <input type="radio"/> Esophagus <input type="radio"/> Kidney <input type="radio"/> Larynx <input type="radio"/> Leukemia <input type="radio"/> Lymphoma <input type="radio"/> Ovary <input type="radio"/> Pancreas <input type="radio"/> Prostate <input type="radio"/> Skin <input type="radio"/> Stomach <input type="radio"/> Thyroid <input type="radio"/> Trachea/Bronchus/Lung <input type="radio"/> Other
<b>Cancer or tumor site for "Other" - #3 ([cancersite3])</b>	<input type="text"/>

<b>Diagnosis - #3 ([cancersite3])</b>	<input type="radio"/> Cancer <input type="radio"/> Maybe cancer <input type="radio"/> Benign
<b>Have medical encounter details been entered on M01 Medical Encounters - #3 ([cancersite3])</b>	<input type="radio"/> No <input type="radio"/> Yes
<b>If "No"</b>	
<b>Year first diagnosed - #3 ([cancersite3])</b>	<input type="text"/> 2002-2021, 9999 = Unknown
<b>DATE details - #3 ([cancersite3])</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input type="text"/>
<b>Name of MD - #3 ([cancersite3])</b>	<input type="text"/>
<b>Location of MD - #3 ([cancersite3])</b>	<input type="text"/> City, State
<b>Was a diagnostic biopsy done at a different location? - #3 ([cancersite3])</b>	<input type="radio"/> No <input type="radio"/> Yes
<b>If "Yes"</b>	
<b>Year of biopsy - #3 ([cancersite3])</b>	<input type="text"/> 2002-2021, 9999 = Unknown
<b>DATE details for biopsy - #3 ([cancersite3])</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc)	<input type="text"/>
<b>Name of MD for biopsy - #3 ([cancersite3])</b>	<input type="text"/>
<b>Location of biopsy - #3 ([cancersite3])</b>	<input type="text"/> City, State
<b>Have you had a fourth cancer or tumor?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Unknown
<b>If "Yes" or "Maybe"</b>	
<b>Cancer or tumor - #4</b>	<input type="radio"/> Bladder <input type="radio"/> Brain <input type="radio"/> Breast <input type="radio"/> Cervix/Uteru <input type="radio"/> Colon/Rectum <input type="radio"/> Esophagus

- ☐ Kidney
- ☐ Larynx
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Ovary
- ☐ Pancreas
- ☐ Prostate
- ☐ Skin
- ☐ Stomach
- ☐ Thyroid
- ☐ Trachea/Bronchus/Lung
- ☐ Other

**Cancer or tumor site for "Other" - #4 ([cancersite4])**

**Diagnosis - #4 ([cancersite4])**

- ☐ Cancer
- ☐ Maybe cancer
- ☐ Benign

**Have medical encounter details been entered on M01 Medical Encounters - #4 ([cancersite4])**

- ☐ No
- ☐ Yes

**If "No"**

**Year first diagnosed - #4 ([cancersite4])**

2002-2021,  
9999 = Unknown

**DATE details - #4 ([cancersite4])**  
(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

**Name of MD - #4 ([cancersite4])**

**Location of MD - #4 ([cancersite4])**

City, State

**Was a diagnostic biopsy done at a different location? - #4 ([cancersite4])**

- ☐ No
- ☐ Yes

**If "Yes"**

**Year of biopsy - #4 ([cancersite4])**

2002-2021,  
9999 = Unknown

**DATE details for biopsy - #4 ([cancersite4])**  
(e.g. 10/2, April, Summer, August-Nov., Unknown etc)

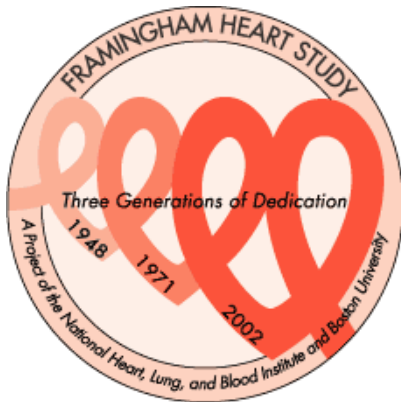
**Name of MD for biopsy - #4 ([cancersite4])**

<b>Location of biopsy - #4 ([cancersite4])</b>	<input type="text"/>
	City, State
<b>Have you had a fifth cancer or tumor?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Unknown
<b>If "Yes" or "Maybe"</b>	
Cancer or tumor - #5	<input type="radio"/> Bladder <input type="radio"/> Brain <input type="radio"/> Breast <input type="radio"/> Cervix/Uteru <input type="radio"/> Colon/Rectum <input type="radio"/> Esophagus <input type="radio"/> Kidney <input type="radio"/> Larynx <input type="radio"/> Leukemia <input type="radio"/> Lymphoma <input type="radio"/> Ovary <input type="radio"/> Pancreas <input type="radio"/> Prostate <input type="radio"/> Skin <input type="radio"/> Stomach <input type="radio"/> Thyroid <input type="radio"/> Trachea/Bronchus/Lung <input type="radio"/> Other
<b>Cancer or tumor site for "Other" - #5 ([cancersite5])</b>	<input type="text"/>
<b>Diagnosis - #5 ([cancersite5])</b>	<input type="radio"/> Cancer <input type="radio"/> Maybe cancer <input type="radio"/> Benign
<b>Have medical encounter details been entered on M01 Medical Encounters - #5 ([cancersite5])</b>	<input type="radio"/> No <input type="radio"/> Yes
<b>If "No"</b>	
<b>Year first diagnosed - #5 ([cancersite5])</b>	<input type="text"/> 2002-2021, 9999 = Unknown
<b>DATE details - #5 ([cancersite5])</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc.)	<input type="text"/>

<b>Name of MD - #5 ([cancersite5])</b>	<input type="text"/>
<b>Location of MD - #5 ([cancersite5])</b>	<input type="text"/> City, State
<b>Was a diagnostic biopsy done at a different location? - #5 ([cancersite5])</b>	<input type="radio"/> No <input type="radio"/> Yes
<b>If "Yes"</b>	
<b>Year of biopsy - #5 ([cancersite5])</b>	<input type="text"/> 2002-2021, 9999 = Unknown
<b>DATE details for biopsy - #5 ([cancersite5])</b> (e.g. 10/2, April, Summer, August-Nov., Unknown etc)	<input type="text"/>
<b>Name of MD for biopsy - #5 ([cancersite5])</b>	<input type="text"/>
<b>Location of biopsy - #5 ([cancersite5])</b>	<input type="text"/> City, State

### Additional Comments

**Cancer**



## Framingham Heart Study

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### ECG

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For OFFSITE exams

- ECG is completed by MD after exam form is returned to FHS site.
- **TECH ONLY** if exam is OFFSITE, select "SAVE and go to Next Form".

---

#### OFFSITE ONLY

MD ID#

## Rhythm

Rhythm - predominant

- ☐ Normal sinus (including s. tach, s. brady, s. arrhy, 1 degree AV block)
- ☐ 2nd degree AV block, Mobitz I (Wenckebach)
- ☐ 2nd degree AV block, Mobitz II
- ☐ 3rd degree AV block / AV dissociation
- ☐ Atrial fibrillation / atrial flutter
- ☐ Nodal
- ☐ Paced
- ☐ Other or combination of above (list)

If "Other or combination of above (list)"

Specify combination

## Ventricular Conduction Abnormalities

IV block

- ☐ No
- ☐ Yes
- ☐ Fully paced or Unknown

If "Yes"

Pattern

- ☐ Left
- ☐ Right
- ☐ Indeterminate
- ☐ Unknown

IV block complete or incomplete

- ☐ Incomplete (QRS interval < .12 sec)
- ☐ Complete (QRS interval >= .12 sec)
- ☐ Unknown

Hemiblock

- ☐ No
- ☐ Left anterior
- ☐ Left posterior
- ☐ Fully paced or Unknown

**WPW syndrome**

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Fully paced or Unknown

### Arrhythmias

**Atrial premature beats**

- ☐ No
- ☐ Atrial
- ☐ Atrial aberrant
- ☐ Unknown

**Ventricular premature beats**

- ☐ No
- ☐ Simple
- ☐ Multifoc.
- ☐ Pairs
- ☐ Run
- ☐ R on T
- ☐ Unknown

**Number of ventricular premature beats in 10 seconds  
(see 10 second rhythm strip)**

99 = Unknown

### Myocardial Infarction Location

**Anterior**

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Fully paced or Unknown

**Inferior**

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Fully paced or Unknown

True posterior	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Fully paced or Unknown
----------------	--

## Hypertrophy, Enlargement, and Other ECG Diagnoses

Nonspecific S-T segment abnormality	<input type="radio"/> No <input type="radio"/> S-T depression <input type="radio"/> S-T flattening <input type="radio"/> Other <input type="radio"/> Fully paced or Unknown
-------------------------------------	---

Nonspecific T-wave abnormality	<input type="radio"/> No <input type="radio"/> T inversion <input type="radio"/> T flattening <input type="radio"/> Other <input type="radio"/> Fully paced or Unknown
--------------------------------	--

Atrial enlargement	<input type="radio"/> None <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Both <input type="radio"/> Atrial fibrillation or Unknown
--------------------	---

RVH	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe <input type="radio"/> Fully paced or Unknown
If complete RBBB or LBBB present, code RVH = Unknown	

LVH	<input type="radio"/> No <input type="radio"/> LVH with strain <input type="radio"/> LVH with mild S-T segment abnormality <input type="radio"/> LVH by voltage only <input type="radio"/> Fully paced or Unknown
If complete LBBB present, code LVH = Unknown	
<b>LVH VOLTAGE CRITERIA</b> R > 20mm in any limb lead R > 11mm in AVL R in lead I plus S in lead III >= 25mm R in V5 or V6 --- S in V1 or V2 R >= 25mm S >= 25mm R or S <= 30mm R + S >= 35mm	

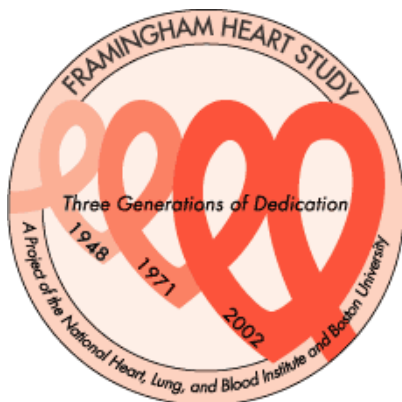
---

**Additional Comments**

---

**ECG**





# Framingham Heart Study

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## Clinical Diagnostic Impression

Heart Diagnoses				
	No	Yes	Maybe	Unknown
Aortic valve disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mitral valve disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurological Disease				
	No	Yes	Maybe	Unknown
Dementia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parkinson's Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adult seizure disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other neurological disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Specify other neurological disease

Additional comments for neurological disease

### Endocrine

	No	Yes	Maybe	Unknown
Thyroid disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes Mellitus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other endocrine disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Specify other endocrine disorders

### GU/ GYN

	No	Yes	Maybe	Unknown
Renal disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify renal disease				

	No	Yes	Maybe	Unknown
Prostate disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No	Yes	Maybe	Unknown
Gynecological problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Specify gynecological problems

## Pulmonary

	No	Yes	Maybe	Unknown
Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pneumonia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obstructive sleep apnea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other pulmonary disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify other pulmonary disease	<input type="text"/>			

## Rheumatologic Disorders

	No	Yes	Maybe	Unknown
Gout	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Degenerative joint disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rheumatoid arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other muscular or connective tissue disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify other muscular or connective tissue disease	<input type="text"/>			

## GI

	No	Yes	Maybe	Unknown
Gallbladder disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GERD/ ulcer disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other GI disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify other GI disease	<input type="text"/>			

## Blood

	No	Yes	Maybe	Unknown
Hematologic disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Infectious Disease

	No	Yes	Maybe	Unknown
Infectious disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify infectious disease	<input type="text"/>			

### Mental Health

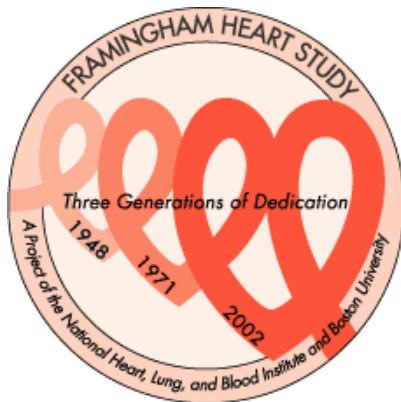
	No	Yes	Maybe	Unknown
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other mental health condition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify other mental health condition	<input type="text"/>			

### Other

	No	Yes	Maybe	Unknown
Eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ear, nose and throat (ENT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Eye, ENT or Skin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify other Eye, ENT or Skin	<input type="text"/>			

### Additional Comments

Clinical Diagnostic Impression



## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### Second Examiner Opinions

For OFFSITE exams this form is not completed.  
Choose **"Save and go to Next Form"** to continue.

NO SECOND EXAMINER OPINIONS are required for this participant.  
Choose **"Save and go to Next Form"** to continue.

☐ Form is intentionally left blank

Reason why form was left blank

Second examiner ID number

### FOR ALL SECOND OPINIONS

**Provide initiators, qualities, radiation, severity, timing, presence after procedures done**

---

### Coronary Heart Disease

---

Congestive heart failure      ☐ No    ☐ Yes    ☐ Maybe    ☐ Unknown

Angina pectoris      ☐ No    ☐ Yes    ☐ Maybe    ☐ Unknown

Coronary insufficiency      ☐ No    ☐ Yes    ☐ Maybe    ☐ Unknown

Myocardial infarct      ☐ No    ☐ Yes    ☐ Maybe    ☐ Unknown

---

Provide initiators, qualities, radiation, severity, timing, presence after procedures done for  
**Coronary Heart Disease Opinion**

---

### Intermittent Claudication

---

Intermittent claudication      ☐ No    ☐ Yes    ☐ Maybe    ☐ Unknown

---

Provide initiators, qualities, radiation, severity, timing, presence after procedures done for  
**Intermittent Claudication Opinion**

---

## Cerebrovascular Disease

---

Stroke

☐ No ☐ Yes ☐ Maybe ☐ Unknown

TIA

☐ No ☐ Yes ☐ Maybe ☐ Unknown

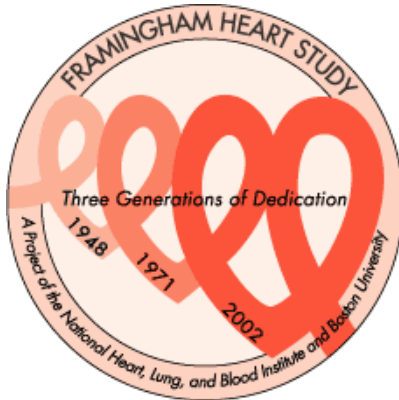
---

Provide initiators, qualities, severity, timing, presence after procedures done for  
**Cerebrovascular Disease Opinion**

## Additional Comments

Second Examiner Opinions





## Framingham Heart Study

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### Referral Tracking

#### Further Medical Evaluation

Was further medical evaluation recommended for this participant?

- ☐ No  
☐ Yes  
☐ Unknown

#### Result

**Check ALL that apply**

Blood pressure -

1st BP: [sys1] / [dia1]

2nd BP: [sys2] / [dia2]

☐ Yes

Phone call if SBP  $\geq$  200 or DBP  $\geq$  110

Expedite if SBP  $\geq$  180 or DBP  $\geq$  100

Elevated if SBP  $\geq$  140 or DBP  $\geq$  90

ECG abnormality	<input type="checkbox"/> Yes
Specify abnormality	<input type="text"/>
Clinic physician identified medical problem	<input type="checkbox"/> Yes
Specify medical problem	<input type="text"/>
Other	<input type="checkbox"/> Yes
Specify other	<input type="text"/>

### Method Used to Inform Participant

[Check ALL that apply](#)

	Yes
Face-to-face in clinic	<input type="checkbox"/>
Phone call	<input type="checkbox"/>
Result letter	<input type="checkbox"/>
Other	<input type="checkbox"/>

### Method Used to Inform Participant's Personal Physician

[Check ALL that apply](#)

	Yes
Phone call	<input type="checkbox"/>
Result letter mailed	<input type="checkbox"/>
Result letter FAX'd - inform staff if FAX needed	<input type="checkbox"/>
Other method - Physician	<input type="checkbox"/>

### Referral Date and Other Information

Date referral made	<input type="text"/>  Today M-D-Y
ID number of person completing referral	<input type="text"/> 

Notes documenting conversation with participant or participant's personal physician

---

**For Omni participants only: Which language was primarily used in conversing with the participant?**

- ☐ English
- ☐ Spanish
- ☐ Mixed
- ☐ Unknown

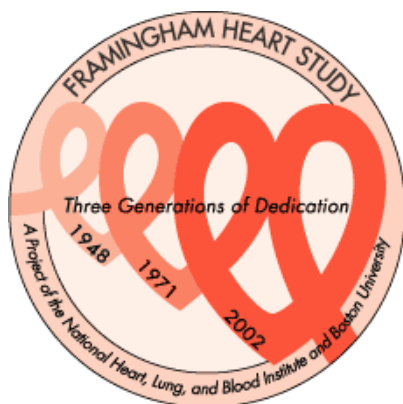
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### **Additional Comments**

---

#### **Referral Tracking**





## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### LETTER TO PHYSICIAN:

#### RESEARCH EXAMINATION REPORT GEN3/Omni Group 2 EXAM 3

Dear Dr. Smith:

Your patient named above participated in a research examination at the Framingham Heart Study.

Please keep in mind that the research examination at the Heart Study is not clinical care. The testing is done for research purposes only and should not be relied on to make any diagnosis, treatment, or health planning decisions. The research examination does not take place of medical care by a physician or health care provider and cannot be relied upon to identify heart or other health conditions.

Below are the blood pressure readings on your patient from the research examination. Enclosed are cholesterol/blood glucose measurements and an ECG on your patient.

---

**BLOOD PRESSURE:****Systolic Blood Pressure:****Diastolic Blood Pressure:**

---

We recommend that you follow up with your patient on any research findings that may be clinically significant.

**Information From Medical History Interview and Routine Research Testing:**

We have recommended your patient follow up with you regarding the following research findings.

---

1 \_\_\_\_\_

---

2 \_\_\_\_\_

---

3 \_\_\_\_\_

You may include up to ten statements.

Some research findings may be sent in a separate report.

---

4 \_\_\_\_\_

---

5 \_\_\_\_\_

---

6 \_\_\_\_\_

---

7 \_\_\_\_\_

---

8 \_\_\_\_\_

---

9 \_\_\_\_\_

---

10 \_\_\_\_\_

---

If you have any questions, please do not hesitate to contact me.

Examiner \_\_\_\_\_

**Daniel Levy, MD**

**Director, Framingham Heart Study**

**OMB No = 0925-0216 12/31/2016**

---

**LETTER TO PARTICIPANT:**

---

**Dear Mr/Ms [lastname]:**

**Thank you again for participating in the research examination at the Framingham Heart Study. In your consent form, you gave permission to provide findings of non-genetic research tests to you and/or your physician or other health care provider. We are now providing you and your health care provider some findings as described below.**

**Please keep in mind that the research examination you had at the Heart Study is not clinical care and the testing is done for research purposes only and should not be relied on to make any diagnosis, treatment, or health planning decisions. The research examination does not take the place of medical care by your own physician or health care provider and cannot be relied upon to identify heart or other health conditions.**

Enclosed are some findings from the research examination about your cholesterol/blood glucose measurements and your ECG.

These findings have been forwarded to your doctor or health care provider:

**PARTICIPANT'S PHYSICIAN(S) LISTED HERE**

We want to point out the following findings that we believe require follow up with your health care provider:

--

If you have any questions, please contact Maureen Valentino, the FHS participant coordinator at the Framingham Heart Study: 508 935 3417 / 800 536 4143.

We look forward to seeing you again and appreciate your support. Your participation in the Framingham Heart Study makes possible our efforts to identify the cause of heart disease and other major health conditions.

Thank you for your continuing support.

Examiner\_\_\_\_\_

Sincerely,

Daniel Levy, MD  
Director, Framingham Heart Study

OMB No = 0925-0216 12/31/2016

2	_____
3	_____
4	_____
5	_____
6	_____
7	_____
8	_____
9	_____
10	_____



# Framingham Heart Study

Generation 3, NOS, Omni 2

## EXAM 3

### Research Center Questionnaire

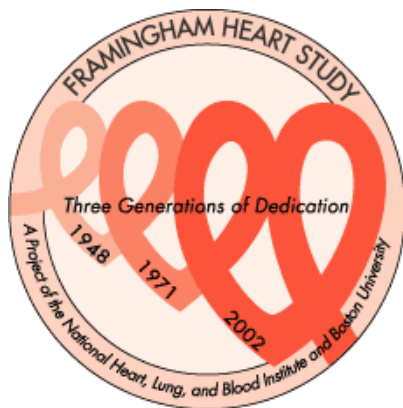
SECTIONS:

Admit	(pages 1 – 6) plus consents
MD	(pages 7 – 112)
Self-Administered Questions	(pages 113 – 142)
Tech	(pages 143 – 174)
Tonometry	(pages 175 – 177)

---

## Self-Administered Questions Section





## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### General Information (Sociodemographic)

---

#### What is your current marital status?

- ☐ Single or never married
- ☐ Married or living as married or living with partner
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ 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.

- ☐ No schooling
- ☐ Grades 1-8
- ☐ Grades 9-11
- ☐ Completed high school (12th grade) or GED
- ☐ Some college but no degree

- ☐ Technical school certificate
- ☐ Associate degree (Junior college AA, AS)
- ☐ Bachelor's degree (BA, AB, BS)
- ☐ Graduate or professional (master's, doctorate, MD etc.)
- ☐ Prefer not to answer

---

**Please choose which of the following best describes your current employment status?**

- ☐ Homemaker, not working outside the home
- ☐ Employed (or self-employed) **full time**
- ☐ Employed (or self-employed) **part time**
- ☐ Employed, but **on leave for health reasons**
- ☐ Employed, but **temporarily away from my job**
- ☐ Unemployed or **laid off**
- ☐ Retired from usual occupation and **not working**
- ☐ Retired from usual occupation but **working for pay**
- ☐ Retired from usual occupation but **volunteering**
- ☐ Unemployed due to **disability**
- ☐ Full-time student
- ☐ Prefer not to answer

---

**What is your current occupation?**

[Write in occupation](#)

---

**From the drop down menu, please choose the code that BEST describes your occupation.**  
**Be sure to scroll down to view all choices.**

- ☐ Administrative (e.g. Personnel)
- ☐ Artist/Graphic Designer/Craftsperson
- ☐ Banker/Accountant
- ☐ Clergy (Minister, Priest, Rabbi)
- ☐ Educator
- ☐ Engineer/Computer Science
- ☐ Factory/Assembly
- ☐ General Labor (e.g. Custodian, Delivery, Mailman, Truck driver)
- ☐ Heavy Labor (e.g. Construction, Landscaping)
- ☐ Homemaker
- ☐ Laboratory Technician
- ☐ Lawyer/Judge
- ☐ M.D./Dentist
- ☐ Manager/Consultant (e.g. Production Manager)
- ☐ Mechanic
- ☐ Musician

- ☐ Nurse/Medical Personnel
- ☐ Physical/Occupational/Speech Therapist
- ☐ Police/Fire/Security/Military
- ☐ Psychologist/Social Worker/Mental Health Counselor
- ☐ Realtor
- ☐ Restaurant/Food worker
- ☐ Retail/Cashier
- ☐ Retired
- ☐ Sales/Marketing/Insurance
- ☐ Scientist/Research
- ☐ Secretary/Clerk/Data Entry
- ☐ Self Employed Business Owner
- ☐ Skilled Labor (e.g. Plumber, Carpenter, Painter Hairdresser)
- ☐ Sports Pro/Coach/Exercise Instructor
- ☐ Statistician
- ☐ Student
- ☐ Writer/Editor
- ☐ Other

---

**Please select the income group that best represents your combined family income for the past 12 months.**

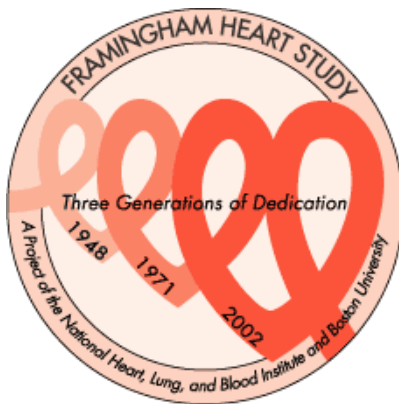
- ☐ Under \$20,000
- ☐ \$20,000 - \$34,999
- ☐ \$35,000 - \$54,999
- ☐ \$55,000 - \$74,999
- ☐ \$75,000 - \$100,000
- ☐ Over \$100,000
- ☐ Prefer not to answer

---

**How many people are supported by this income?**

(e.g. 1, 2, 3, ...)





## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### Health Insurance and Medications

#### Health Insurance

Do you currently have health insurance?

- ☐ No
- ☐ Yes
- ☐ Prefer not to answer
- ☐ Don't know

If "Yes", check all that apply

	Yes
Blue Cross Blue Shield	<input type="checkbox"/>
Harvard-Pilgrim	<input type="checkbox"/>
Tufts	<input type="checkbox"/>

<b>Aetna</b>	<input type="checkbox"/>
<b>United Health Care</b>	<input type="checkbox"/>
<b>Medicare</b>	<input type="checkbox"/>
<b>Medicaid</b>	<input type="checkbox"/>
<b>Military or Veterans Administration sponsored</b>	<input type="checkbox"/>
<b>Other health insurance</b>	<input type="checkbox"/>

**Do you have prescription drug coverage?**

- ☐ No
- ☐ Yes
- ☐ Prefer not to answer
- ☐ Don't know

## Medication

**Do you take any medications?**

- ☐ No
- ☐ Yes
- ☐ Don't know

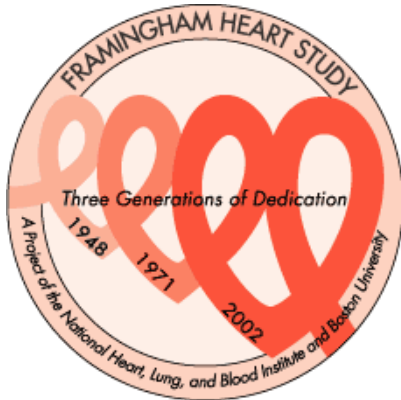
**If "Yes"**

The questions below refer to medication recommended to you by your doctor or health care provider.

	No	Yes	Unknown
<b>Did you ever forget to take your medicine?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Are you careless at times about taking your medicine?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>When you feel better do you stop taking your medicine?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Sometimes if you feel worse when you take the medicine, do you stop taking it?</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**How often do you forget to take your medicine?**

- ☐ Never
- ☐ More than once per week
- ☐ Once per week
- ☐ More than once per month
- ☐ Once per month
- ☐ Less than once per month
- ☐ Unknown



# Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

## Health Survey (SF-12) part 1

---

**This questionnaire asks for your views about your health.**

**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?

---

2. Moderate activities, **such as moving a table, pushing a vacuum cleaner, bowling, or playing golf**

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

---

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

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

---

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?

---

4. Accomplished less **than you would like**

- ☐ Yes
- ☐ No

---

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

- ☐ Yes
- ☐ No

---

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)?

---

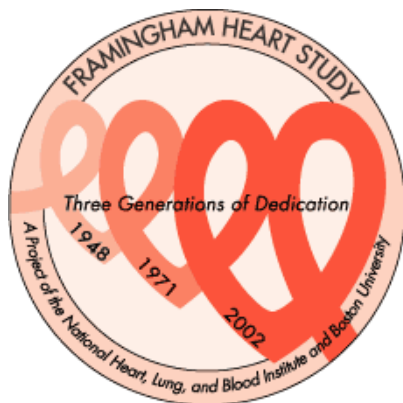
6. Accomplished less **than you would like**

- ☐ Yes
- ☐ No

---

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

- ☐ Yes
- ☐ No



## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### Health Survey (SF-12) part 2

---

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

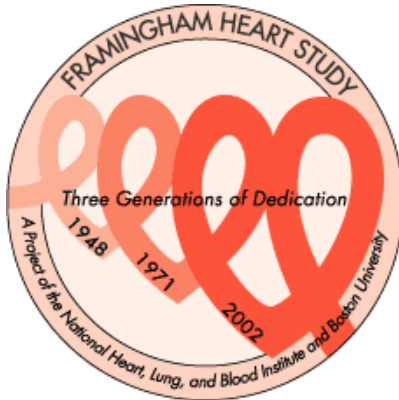
These questions are about how you feel and how things have been with you during the past 4 weeks.  
For each question, please give the one answer that comes closest to the way you have been feeling.

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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Have you felt downhearted and blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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



# Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

## Bleeding History

---

**Have you been diagnosed with a bleeding disorder?**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**If "Yes"**

---

**What is the name of the bleeding disorder?**

- ☐ von Willebrand disease
- ☐ Hemophilia A
- ☐ Hemophilia B
- ☐ Platelet function disorder
- ☐ Immune thrombocytopenia (ITP)
- ☐ Other

---

If "Other" write in

If unsure, write "unsure"

---

Your age at diagnosis

If unsure, write "unsure"

---

Name of treating doctor

If unsure, write "unsure"

---

Name of hospital or practice and location (city, state)

If unsure, write "unsure"

---

Does ANYONE in your family have a history of BLEEDING problems or complications?

For example: frequent or prolonged nosebleeds, prolonged or excessive bleeding or bruising after cuts or trauma, excessive bleeding after dental, other medical or surgical procedures, heavy bleeding with periods or after delivery of a baby

- ☐ No
  - ☐ Yes
  - ☐ Don't know
- 

If "Yes"

1. Please indicate if any biologically-related family members have or have had bleeding problems.

---

Mother

- ☐ No
  - ☐ Yes
  - ☐ Don't know
- 

Mother's side - **Grandmother**

- ☐ No
  - ☐ Yes
  - ☐ Don't know
- 

Mother's side - **Grandfather**

- ☐ No
  - ☐ Yes
  - ☐ Don't know
-

---

Father

- ☐ No
- ☐ Yes
- ☐ Don't know

---

Father's side - **Grandmother**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

Father's side - **Grandfather**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**2. Please indicate the number of biologically-related family members you have and if any of them have or have had bleeding problems.**

---

**Total number of biologically-related brothers (WITH or WITHOUT bleeding problems)**

- ☐ No brothers
- ☐ 1 brother
- ☐ 2 brothers
- ☐ 3 brothers
- ☐ 4 brothers
- ☐ 5 or more brothers
- ☐ Don't know

---

**Total number of biologically-related brothers WITH bleeding problems**

- ☐ No brothers
- ☐ 1 brother
- ☐ 2 brothers
- ☐ 3 brothers
- ☐ 4 brothers
- ☐ 5 or more brothers
- ☐ Don't know

---

**Total number of biologically-related sisters (WITH or WITHOUT bleeding problems)**

- ☐ No sisters
- ☐ 1 sister
- ☐ 2 sisters
- ☐ 3 sisters

- ☐ 4 sisters
- ☐ 5 or more sisters
- ☐ Don't know

---

**Total number of biologically-related sisters WITH bleeding problems**

- ☐ No sisters
- ☐ 1 sister
- ☐ 2 sisters
- ☐ 3 sisters
- ☐ 4 sisters
- ☐ 5 or more sisters
- ☐ Don't know

---

**Mother's side:**

---

**Mother's side - Total number of biologically-related aunts (WITH or WITHOUT bleeding problems)**

- ☐ No aunts
- ☐ 1 aunt
- ☐ 2 aunts
- ☐ 3 aunts
- ☐ 4 aunts
- ☐ 5 or more aunts
- ☐ Don't know

---

**Mother's side - Total number of biologically-related aunts WITH bleeding problems**

- ☐ No aunts
- ☐ 1 aunt
- ☐ 2 aunts
- ☐ 3 aunts
- ☐ 4 aunts
- ☐ 5 or more aunts
- ☐ Don't know

---

**Mother's side - Total number of biologically-related uncles (WITH or WITHOUT bleeding problems)**

- ☐ No uncles
- ☐ 1 uncle
- ☐ 2 uncles
- ☐ 3 uncles
- ☐ 4 uncles
- ☐ 5 or more uncles
- ☐ Don't know

---

Mother's side - **Total number of biologically-related uncles WITH bleeding problems**

- ☐ No uncles
- ☐ 1 uncle
- ☐ 2 uncles
- ☐ 3 uncles
- ☐ 4 uncles
- ☐ 5 or more uncles
- ☐ Don't know

---

**Father's side:**

---

Father's side - **Total number of biologically-related aunts (WITH or WITHOUT bleeding problems)**

- ☐ No aunts
- ☐ 1 aunt
- ☐ 2 aunts
- ☐ 3 aunts
- ☐ 4 aunts
- ☐ 5 or more aunts
- ☐ Don't know

---

Father's side - **Total number of biologically-related aunts WITH bleeding problems**

- ☐ No aunts
- ☐ 1 aunt
- ☐ 2 aunts
- ☐ 3 aunts
- ☐ 4 aunts
- ☐ 5 or more aunts
- ☐ Don't know

---

Father's side - **Total number of biologically-related uncles (WITH or WITHOUT bleeding problems)**

- ☐ No uncles
- ☐ 1 uncle
- ☐ 2 uncles
- ☐ 3 uncles
- ☐ 4 uncles
- ☐ 5 or more uncles
- ☐ Don't know

---

Father's side - **Total number of biologically-related uncles WITH bleeding problems**

- ☐ No uncles
- ☐ 1 uncle

- ☐ 2 uncles
- ☐ 3 uncles
- ☐ 4 uncles
- ☐ 5 or more uncles
- ☐ Don't know

---

**3. Describe the type(s) of bleeding problems or bleeding complications in your family.**

[Write in text](#)

---

**Have YOU ever required medical attention due to a nosebleed that was not associated with a trauma, or had a nosebleed lasting more than 10 minutes?**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**Have YOU ever experienced frequent or heavy bruising (raised bruise or a bruise greater than the size of a quarter) not caused by a trauma OR out of proportion to the size of the trauma?**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**Have YOU ever experienced prolonged bleeding (more than 5 minutes) when you bit yourself on the lip, cheek or tongue?**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**Have YOU ever experienced prolonged bleeding (more than 5 minutes) with minor bodily cuts?**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**During or after a dental visit, have YOU ever experienced prolonged bleeding that required serious medical attention related to a cleaning OR tooth extraction OR other dental procedure?**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

If "Yes"

How many dental procedures (including cleaning) have you had in total (WITH or WITHOUT serious bleeding)?

- ☐ Less than 3 procedures
- ☐ 3-10 procedures
- ☐ 11 or more procedures
- ☐ Don't know

Of these dental procedures, how many times did you experience a prolonged bleeding problem?

Write in a number. If unsure write "unsure"

Was a surgical procedure (e.g., stitching, restitching or packing) required to control bleeding?

- ☐ No
- ☐ Yes
- ☐ Don't know

---

If "Yes"

Name of treating dentist:

If unsure write "unsure"

Name of practice and location (city, state):

If unsure, write "unsure"

Have YOU ever experienced serious bleeding after a surgical procedure that required medical attention (for example: delay in discharge, extra procedures, restitching, packing, readmission, transfusion)?

- ☐ No
- ☐ Yes
- ☐ Don't know

---

If "Yes"

How many total surgeries have you had (with or without serious bleeding)?

- ☐ 1-2 surgeries
- ☐ 3-4 surgeries
- ☐ 5-6 surgeries
- ☐ 7 or more surgeries
- ☐ Don't know

For the surgeries with the most serious bleeding, answer the following questions.

---

**Age at surgery - surgery #1**

Write in age. If unsure write "unsure"

---

**Type of surgery - surgery #1**

- ☐ Abdominal (belly)
- ☐ Thoracic (heart or lungs)
- ☐ Gynecology
- ☐ Throat/Nose
- ☐ Tonsillectomy/Adenoids
- ☐ Other (e.g., orthopedic, spine, CNS: central nervous system)

---

**If "Other" write in - surgery #1**

If unsure, write "unsure"

---

**Were any action(s) taken to control the bleeding - surgery #1**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**If "Yes"**

	No	Yes	Don't know
Restitching or surgical - surgery #1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood transfusion - surgery #1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (clotting medication, etc.) - surgery #1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

---

**If "Other" write in - surgery #1**

If unsure, write "unsure"

---

**If "Yes" to "Restitching or surgical" OR "Blood transfusion" OR "Other"**

---

**Name of treating doctor - surgery #1**

If unsure, write "unsure"

---

**Name of practice and location (city, state) - surgery #1**

If unsure, write "unsure"

---

**Did you have a 2nd surgery with bleeding problems?**

- ☐ No
- ☐ Yes

If "Yes"

Age at surgery - surgery #2

Write in age. If unsure write "unsure"

Type of surgery - surgery #2

- ☐ Abdominal (belly)
- ☐ Thoracic (heart or lungs)
- ☐ Gynecology
- ☐ Throat/Nose
- ☐ Tonsillectomy/Adenoids
- ☐ Other

If "Other" write in - surgery #2

If unsure, write "unsure"

Were any action(s) taken to control the bleeding - surgery #2

- ☐ No
- ☐ Yes
- ☐ Don't know

If "Yes"

	No	Yes	Don't know
Restitching or surgical - surgery #2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood transfusion - surgery #2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (clotting medication, etc.) - surgery #2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If "Other" write in - surgery #2

If unsure, write "unsure"

If "Yes" to "Restitching or surgical" OR "Blood transfusion" OR "Other"

Name of treating doctor - surgery #2

If unsure, write "unsure"

Name of practice and location (city, state) - surgery #2

If unsure, write "unsure"

Did you have a 3rd surgery with bleeding problems?

- ☐ No  
☐ Yes

If "Yes"

Age at surgery - surgery #3

Write in age. If unsure write "unsure"

Type of surgery - surgery #3

- ☐ Abdominal (belly)  
☐ Thoracic (heart or lungs)  
☐ Gynecology  
☐ Throat/Nose  
☐ Tonsillectomy/Adenoids  
☐ Other

If "Other" write in - surgery #3

If unsure, write "unsure"

Were any action(s) taken to control the bleeding - surgery #3

- ☐ No  
☐ Yes  
☐ Don't know

If "Yes"

	No	Yes	Don't know
Restitching or surgical - surgery #3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood transfusion - surgery #3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (clotting medication etc.) - surgery #3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If "Other" write in - surgery #3

If unsure, write "unsure"

If "Yes" to "Restitching or surgical" OR "Blood transfusion" OR "Other"

Name of treating doctor - surgery #3

If unsure, write "unsure"

Name of practice and location (city, state) - surgery #3

If unsure, write "unsure"

Did you have a 4th surgery with bleeding problems?

- ☐ No  
☐ Yes

If "Yes"

Age at surgery - surgery #4

Write in age. If unsure write "unsure"

Type of surgery - surgery #4

- ☐ Abdominal (belly)  
☐ Thoracic (heart or lungs)  
☐ Gynecology  
☐ Throat/Nose  
☐ Tonsillectomy/Adenoids  
☐ Other

If "Other" write in - surgery #4

If unsure, write "unsure"

Were any action(s) taken to control the bleeding - surgery #4

- ☐ No  
☐ Yes  
☐ Don't know

If "Yes"

	No	Yes	Don't know
Restitching or surgical - surgery #4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood transfusion - surgery #4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (clotting medication etc.) - surgery #4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If "Other" write in - surgery #4

If unsure, write "unsure"

If "Yes" to "Restitching or surgical" OR "Blood transfusion" OR "Other"

Name of treating doctor - surgery #4

If unsure, write "unsure"

Name of practice and location (city, state) - surgery #4

If unsure, write "unsure"

Did you have a 5th surgery with bleeding problems?

- ☐ No  
☐ Yes

If "Yes"

Age at surgery - surgery #5

Write in age. If unsure write "unsure"

Type of surgery - surgery #5

- ☐ Abdominal (belly)  
☐ Thoracic (heart or lungs)  
☐ Gynecology  
☐ Throat/Nose  
☐ Tonsillectomy/Adenoids  
☐ Other

If "Other" write in - surgery #5

If unsure, write "unsure"

Were any action(s) taken to control the bleeding - surgery #5

- ☐ No  
☐ Yes  
☐ Don't know

If "Yes"

	No	Yes	Don't know
Restitching or surgical - surgery #5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood transfusion - surgery #5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (clotting medication etc.) - surgery #5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

---

If "Other" write in - surgery #5

If unsure, write "unsure"

---

If "Yes" to "Restitching or surgical" OR "Blood transfusion" OR "Other"

Name of treating doctor - surgery #5

If unsure, write "unsure"

Name of practice and location (city, state) - surgery #5

If unsure, write "unsure"

---

Have YOU ever been told by a doctor or healthcare provider to stop using a medication because you had bleeding problems?

- ☐ No
- ☐ Yes
- ☐ Don't know

---

If "Yes"

What was the name of the medication(s) you were told to stop taking due to bleeding problems?

If unsure, write "unsure"

Name(s) of treating doctor who told you to stop:

If unsure, write "unsure"

Name of hospital or practice and location (city, state):

If unsure, write "unsure"

---

Have YOU ever experienced OR been told you have any of the following?

Skin bleeding tiny purple spots particularly on the legs (petechiae)

- ☐ No
- ☐ Yes
- ☐ Don't know

---

If "Yes"

How many times do you experience this per year?

- ☐ Less than 1 time
- ☐ 1-5 times
- ☐ 6-12 times
- ☐ More than 12 times

---

**Spontaneous gum or mouth bleeding**

(do not include bleeding with tooth brushing, flossing or trauma, or gum bleeding related to gum disease)

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**If "Yes"**

How many times do you experience this per year?

- ☐ Less than 1 time
- ☐ 1-5 times
- ☐ 6-12 times
- ☐ More than 12 times

---

**Have you had excessive bleeding with your period (menorrhagia) that required medical attention or treatment?**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**If "Yes"**

As a result of excessive bleeding did you have any of the following treatments?

	No	Yes	Don't know
Office visit or consultation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hormonal contraception (pill or injection)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hormonal IUD (e.g., Mirena, Skyla, Liletta)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-hormonal IUD (copper-ParaGard)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Iron supplement for anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hysterectomy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Endometrial ablation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Antifibrinolytic (e.g., Amicar-aminocaproic, Lysteda-tranexamic acid)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood transfusion (including platelets or plasma only)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

---

If "Other" write in

If unsure, write "unsure"

---

**What was your age when you had your first excessive bleeding problem with your period that required medical attention?**

Write in age. If unsure write "unsure"

---

**Have you had excessive bleeding with or after the delivery of a baby requiring medical intervention (post-partum hemorrhage)?**

- ☐ No  
☐ Yes  
☐ Don't know
- 

**If "Yes"**

**How many deliveries have you had in total?**

Write in a number. If unsure write "unsure"

---

**How many vaginal deliveries have you had in total?**

Write in a number. If unsure write "unsure"

---

**How many caesarean sections have you had in total?**

Write in a number. If unsure write "unsure"

---

**Answer the following questions about your vaginal deliveries that had excessive bleeding requiring medical intervention.**

**Was any instrumentation used in the delivery (e.g. forceps)? - delivery #1**

- ☐ No  
☐ Yes  
☐ Don't know
- 

**Age at delivery? - delivery #1**

Write in age. If unsure of age write "unsure"

---

**Was surgical treatment required to control the bleeding? - delivery #1**

- ☐ No  
☐ Yes  
☐ Don't know
-

---

**Did you receive a blood transfusion? - delivery #1**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**If "Yes" to surgical treatment to control bleeding OR blood transfusion**

**Name of treating doctor - delivery #1**

If unsure, write "unsure"

---

**Name of hospital or practice and location (city, state) - delivery #1**

If unsure, write "unsure"

---

**Did you have a 2nd vaginal delivery with excess bleeding that required medical intervention?**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**If "Yes"**

---

**Was any instrumentation used in the delivery (e.g. forceps)? - delivery #2**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**Age at delivery? - delivery #2**

Write in age. If unsure of age write "unsure"

---

**Was surgical treatment required to control the bleeding? - delivery #2**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**Did you receive a blood transfusion? - delivery #2**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**If "Yes" to surgical treatment to control bleeding OR blood transfusion**

**Name of treating doctor - delivery #2**

If unsure, write "unsure"

---

**Name of hospital or practice and location (city, state) - delivery #2**

If unsure, write "unsure"

---

**Did you have a 3rd vaginal delivery with excess bleeding that required medical intervention?**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**If "Yes"**

**Was any instrumentation used in the delivery (e.g. forceps)? - delivery #3**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**Age at delivery? - delivery #3**

Write in age. If unsure of age write "unsure"

---

**Was surgical treatment required to control the bleeding? - delivery #3**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**Did you receive a blood transfusion? - delivery #3**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**If "Yes" to surgical treatment to control bleeding OR blood transfusion**

**Name of treating doctor - delivery #3**

If unsure, write "unsure"

---

**Name of hospital or practice and location (city, state) - delivery #3**

If unsure, write "unsure"

---

**Did you have a 4th vaginal delivery with excess bleeding that required medical intervention?**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

If "Yes"

**Was any instrumentation used in the delivery (e.g. forceps)? - delivery #4**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**Age at delivery? - delivery #4**

Write in age. If unsure of age write "unsure"

---

**Was surgical treatment required to control the bleeding? - delivery #4**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**Did you receive a blood transfusion? - delivery #4**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**If "Yes" to surgical treatment to control bleeding OR blood transfusion**

**Name of treating doctor - delivery #4**

If unsure, write "unsure"

---

**Name of hospital or practice and location (city, state) - delivery #4**

If unsure, write "unsure"

---

**Did you have a 5th vaginal delivery with excess bleeding that required medical intervention?**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

If "Yes"

**Was any instrumentation used in the delivery (e.g. forceps)? - delivery #5**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**Age at delivery? - delivery #5**

Write in age. If unsure of age write "unsure"

---

**Was surgical treatment required to control the bleeding? - delivery #5**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**Did you receive a blood transfusion? - delivery #5**

- ☐ No
- ☐ Yes
- ☐ Don't know

---

**If "Yes" to surgical treatment to control bleeding OR blood transfusion**

**Name of treating doctor - delivery #5**

If unsure, write "unsure"

---

**Name of hospital or practice and location (city, state) - delivery #5**

If unsure, write "unsure"

---

**Do you have any other comments about your own bleeding history OR your family's bleeding history?**



# Framingham Heart Study

Generation 3, NOS, Omni 2

## EXAM 3

### Research Center Questionnaire

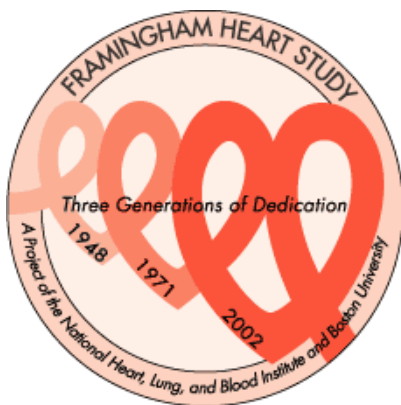
SECTIONS:

Admit	(pages 1 – 6) plus consents
MD	(pages 7 – 112)
Self-Administered Questions	(pages 113 – 142)
Tech	(pages 143 – 174)
Tonometry	(pages 175 – 177)

---

## Tech Section





# Framingham Heart Study

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## Basic Information and Anthropometrics

☐ Form is intentionally left blank

Reason why form was left blank

Technician Number

### Basic Information

What state do you reside in?

- ☐ AL = Alabama
- ☐ AK = Alaska
- ☐ AZ = Arizona
- ☐ AR = Arkansas
- ☐ CA = California
- ☐ CO = Colorado
- ☐ CT = Connecticut

- DC = Washington DC
- DE = Delaware
- FL = Florida
- GA = Georgia
- HI = Hawaii
- ID = Idaho
- IL = Illinois
- IN = Indiana
- IA = Iowa
- KS = Kansas
- KY = Kentucky
- LA = Louisiana
- ME = Maine
- MD = Maryland
- MA = Massachusetts
- MI = Michigan
- MN = Minnesota
- MS = Mississippi
- MO = Missouri
- MT = Montana
- NE = Nebraska
- NV = Nevada
- NH = New Hampshire
- NJ = New Jersey
- NM = New Mexico
- NY = New York
- NC = North Carolina
- ND = North Dakota
- OH = Ohio
- OK = Oklahoma
- OR = Oregon
- PA = Pennsylvania
- RI = Rhode Island
- SC = South Carolina
- SD = South Dakota
- TN = Tennessee
- TX = Texas
- UT = Utah
- VT = Vermont
- VA = Virginia
- WA = Washington

- ☐ WV = West Virginia
- ☐ WI = Wisconsin
- ☐ WY = Wyoming
- ☐ ZZ = Outside United States

If resides outside the USA, code ZZ.  
If plans to wear accelerometer while visiting USA,  
code state of visit.

## Anthropometry

**Weight**

To the nearest pound,  
400 = 400 or more,  
888 = Refused,  
999 = Not done or Unknown

**Protocol modification - Weight**

☐ Yes

**If "Yes"**

**Comments protocol modification - Weight**

**Height**

Inches, to next lower 1/4 inch,  
88.88 = Refused,  
99.99 = Not done or Unknown

**Protocol modification - Height**

☐ Yes

**If "Yes"**

**Comments protocol modification - Height**

**Waist girth at umbilicus**

Inches, to next lower 1/4 inch,  
88.88 = Refused,  
99.99 = Not done or Unknown

**Protocol modification - Waist girth**

☐ Yes

**If "Yes"**

**Comments protocol modification - Waist girth**

**Hip girth**

Inches, to next lower 1/4 inch,  
88.88 = Refused,  
99.99 = Not done or Unknown

**Protocol modification - Hip girth**

☐ Yes

**If "Yes"**

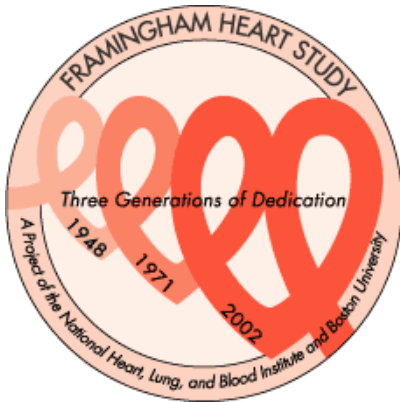
**Comments protocol modification - Hip girth**

---

## Additional Comments

---

### Basic Information and Anthropometry



# Framingham Heart Study

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## Hand Grip Test

<input type="checkbox"/> Form is intentionally left blank	
Reason why form was left blank	<input type="text"/>
Technician Number	<input type="text"/>
Right hand	
Trial 1	<input type="text"/> Nearest kilogram, 99 = Unknown
Trial 2	<input type="text"/> Nearest kilogram, 99 = Unknown
Trial 3	<input type="text"/> Nearest kilogram, 99 = Unknown

Left hand

**Trial 1**

Nearest kilogram,  
99 = Unknown

**Trial 2**

Nearest kilogram,  
99 = Unknown

**Trial 3**

Nearest kilogram,  
99 = Unknown

**Check only if HAND GRIP test was  
NOT completed or NOT attempted?**

☐ Test NOT completed or NOT attempted

**If checked**

**If "Test NOT completed or NOT attempted" why not?**

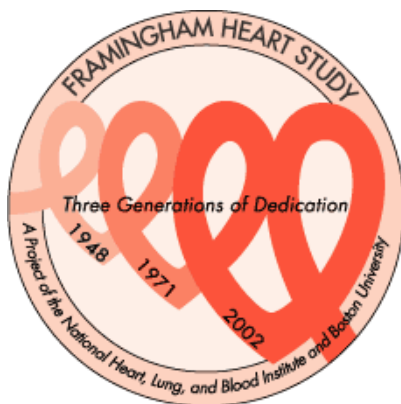
- ☐ Physical limitation
- ☐ Refused
- ☐ Other
- ☐ Unknown

**Other reason test not done**

Write in reason

## Additional Comments

**Hand Grip Test**



## Framingham Heart Study

A Project of the National Heart, Lung, and Blood Institute and Boston University

### CES-D

☐ Form is intentionally left blank

Reason why form was left blank

Technician Number

The next questions ask about your feelings.

For each statement, please say how often you felt that way **DURING THE PAST WEEK**

During the past week, I was bothered by things that don't usually bother me.

- ☐ Rarely or none of the time (less than 1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

<b>I did not feel like eating; my appetite was poor.</b>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<b>I felt that I could not shake off the blues even with the help of my family or friends.</b>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<b>I felt that I was just as good as other people.</b>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<b>I had trouble keeping my mind on what I was doing.</b>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<b>During the past week, I felt depressed.</b>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<b>I felt everything I did was an effort.</b>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<b>I felt hopeful about the future.</b>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<b>I thought my life had been a failure.</b>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>

<p><b>I felt fearful.</b></p>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<p><b>During the past week, my sleep was restless.</b></p>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<p><b>I was happy.</b></p>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<p><b>I talked less than usual.</b></p>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<p><b>I felt lonely.</b></p>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<p><b>People were unfriendly.</b></p>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<p><b>I enjoyed life.</b></p>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>
<p><b>I had crying spells.</b></p>	<ul style="list-style-type: none"> <li><input type="radio"/> Rarely or none of the time (less than 1 day)</li> <li><input type="radio"/> Some or a little of the time (1-2 days)</li> <li><input type="radio"/> Occasionally or a moderate amount of the time (3-4 days)</li> <li><input type="radio"/> Most or all of the time (5-7 days)</li> </ul>

---

**I felt sad.**

- ☐ Rarely or none of the time (less than 1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

---

**I felt that people disliked me.**

- ☐ Rarely or none of the time (less than 1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

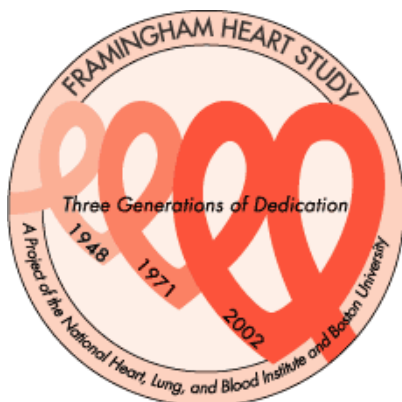
---

**I could not "get going".**

- ☐ Rarely or none of the time (less than 1 day)
  - ☐ Some or a little of the time (1-2 days)
  - ☐ Occasionally or a moderate amount of the time (3-4 days)
  - ☐ Most or all of the time (5-7 days)
- 

### **Additional Comments**

**CES-D**



# Framingham Heart Study

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## Rosow-Breslau Questions

☐ Form is intentionally left blank

Reason why form was left blank

Technician Number

No

Yes

Unknown

Are you able to do heavy work around the house, like shoveling snow or washing windows, walls, or floors without help?

☐
☐
☐

Are you able to walk half a mile without help? (About 4-6 blocks)

☐
☐
☐

Are you able to walk up and down one flight of stairs without help?

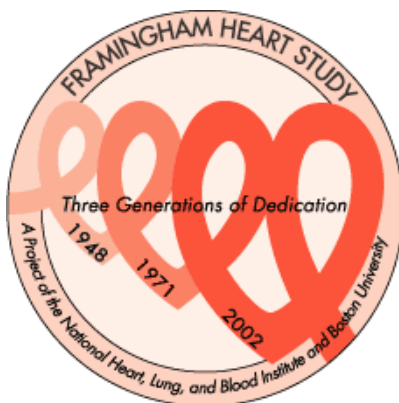
☐
☐
☐

---

### Additional Comments

---

**Rosow-Breslau**



# Framingham Heart Study

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## Physical Activity Index (PAI)

☐ Form is intentionally left blank

Reason why form was left blank

Technician Number

**Rest and Activity for a TYPICAL DAY over the PAST YEAR.**  
**A typical day = most days of the week**

**SLEEP: Number of hours that you typically sleep?**

99 = Unknown

**SEDENTARY: Number of hours typically sitting?**

99 = Unknown

**SLIGHT ACTIVITY: Number of hours with activities such as standing, walking?**

99 = Unknown

---

**MODERATE ACTIVITY: Number of hours with activities such as housework (vacuum, dust, yard chores, climbing stairs, light sports such as bowling, golf)?**

99 = Unknown

---

**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.?**

99 = Unknown

---

Rest and Activity Hours - TOTAL:

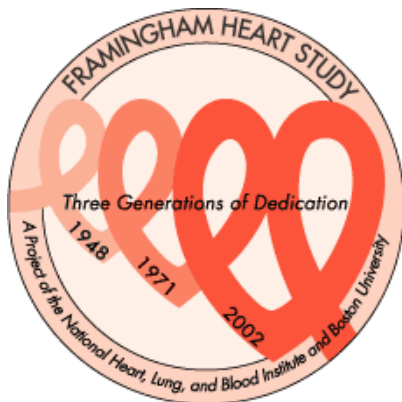
[View equation](#)

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### Additional Comment

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**Physical Activity Index (PAI)**



## Framingham Heart Study

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### Physical Activity Questionnaire - Vigorous Activities

☐ Form is intentionally left blank

Reason why form was left blank

Technician Number

Now I'll ask you about your physical activities. Only include the time spent actually doing the activity. For example, sitting by the pool does not count as time swimming; sitting in a chair lift does not count for skiing.

First I'll ask about VIGOROUS ACTIVITIES. Vigorous activities increase your heart rate, or make you sweat doing them, or make you breathe hard, or raise your body temperature. If you do an activity but not vigorously, please include it later when I ask you about other non-strenuous activities.

For all estimates, round up to nearest whole number.

**In the past 12 months for at least one hour total time in any month did you do the following activities? For example, you may have done three 20 minute sessions in the month.**

**In the past 12 months for at least one hour total time in any month did you do**

Vigorous jogging or running?

- ☐ No
- ☐ Yes
- ☐ Unknown

**If "Yes"**

**How many months did you do this activity?**

99 = Unknown

**How many times per month did you do this activity?**

99 = Unknown

**How long did you do this activity on average each time?**

Number of minutes,  
999 = Unknown

**In the past 12 months for at least one hour total time in any month did you do**

Vigorous racket sports?

- ☐ No
- ☐ Yes
- ☐ Unknown

**If "Yes"**

**How many months did you do this activity?**

99 = Unknown

**How many times per month did you do this activity?**

99 = Unknown

**How long did you do this activity on average each time?**

Number of minutes,  
999 = Unknown

**In the past 12 months for at least one hour total time in any month did you do**

Bicycle faster than 10 miles/hour or exercise hard on an exercise bicycle, elliptical, stair-master, treadmill, etc.

- ☐ No
- ☐ Yes
- ☐ Unknown

**If "Yes"**

**How many months did you do this activity?**

99 = Unknown

**How many times per month did you do this activity?**

99 = Unknown

**How long did you do this activity on average each time?**

Number of minutes,  
999 = Unknown

**In the past 12 months for at least one hour total time in any month did you do**

Vigorous swimming?

- ☐ No
- ☐ Yes
- ☐ Unknown

If "Yes"

How many months did you do this activity?

99 = Unknown

How many times per month did you do this activity?

99 = Unknown

How long did you do this activity on average each time?

Number of minutes,  
999 = Unknown

In the past 12 months for at least one hour total time in any month did you do  
Vigorous exercise class or vigorous dancing?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

How many months did you do this activity?

99 = Unknown

How many times per month did you do this activity?

99 = Unknown

How long did you do this activity on average each time?

Number of minutes,  
999 = Unknown

In the past 12 months for at least one hour total time in any month did you do  
Any vigorous job activities such as lifting, carrying, or digging?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

How many months did you do this activity?

99 = Unknown

How many times per month did you do this activity?

99 = Unknown

How long did you do this activity on average each time?

Number of minutes,  
999 = Unknown

In the past 12 months for at least one hour total time in any month did you do  
Any home activities such as snow shoveling, moving heavy objects, or weight lifting (including weight training)?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

How many months did you do this activity?

99 = Unknown

---

**How many times per month did you do this activity?**

99 = Unknown

---

**How long did you do this activity on average each time?**

Number of minutes,  
999 = Unknown

---

**In the past 12 months for at least one hour total time in any month did you do**

Other strenuous sports such as basketball, football, skating, skiing, soccer, etc.?

- ☐ No  
☐ Yes  
☐ Unknown

---

**If "Yes"**

---

**How many months did you do this activity?**

99 = Unknown

---

**How many times per month did you do this activity?**

99 = Unknown

---

**How long did you do this activity on average each time?**

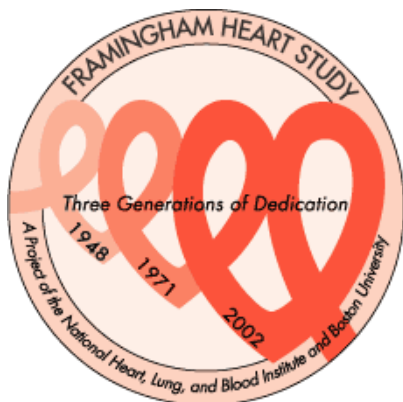
Number of minutes,  
999 = Unknown

---

### **Additional Comments**

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**Physical Activity Questionnaire - Vigorous Activities**



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### Physical Activity Questionnaire - Leisure Activities

☐ Form is intentionally left blank

Reason why form was left blank

Technician Number

#### Leisure Activities

Now, I'd like to ask you about more LEISURE ACTIVITIES.  
In the past 12 months for at least one hour total time in any month did you...

In the past 12 months for at least one hour total time in any month did you...

Do non-strenuous sports such as softball, shooting baskets, volleyball, ping pong, or leisurely jogging, swimming or biking, which we haven't included above?

- ☐ No
- ☐ Yes
- ☐ Unknown

If "Yes"

How many months did you do this activity?

99 = Unknown

How many times per month did you do this activity?

99 = Unknown

How long did you do this activity on average each time?

Number of minutes,  
999 = Unknown

In the past 12 months for at least one hour total time in any month did you...

Take walks or hikes or walk to work?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

How many months did you do this activity?

99 = Unknown

How many times per month did you do this activity?

99 = Unknown

How long did you do this activity on average each time?

Number of minutes,  
999 = Unknown

In the past 12 months for at least one hour total time in any month did you...

Bowl or play golf?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

How many months did you do this activity?

99 = Unknown

How many times per month did you do this activity?

99 = Unknown

How long did you do this activity on average each time?

Number of minutes,  
999 = Unknown

In the past 12 months for at least one hour total time in any month did you...

Do home exercise or calisthenics?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

How many months did you do this activity?

99 = Unknown

How many times per month did you do this activity?

99 = Unknown

How long did you do this activity on average each time?

Number of minutes,  
999 = Unknown

In the past 12 months for at least one hour total time in any month did you...

Do home maintenance or gardening, including carpentry, painting, raking, mowing, etc.?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

How many months did you do this activity?

99 = Unknown

How many times per month did you do this activity?

99 = Unknown

How long did you do this activity on average each time?

Number of minutes,  
999 = Unknown

In the past 12 months for at least one hour total time in any month did you...

Do non-strenuous weight training including free weights or machines such as Nautilus?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

How many months did you do this activity?

99 = Unknown

How many times per month did you do this activity?

99 = Unknown

How long did you do this activity on average each time?

Number of minutes,  
999 = Unknown

## Leisure Time

My next question is about your LEISURE TIME

In the past week, about how many hours per day did you sit and watch TV or videos?

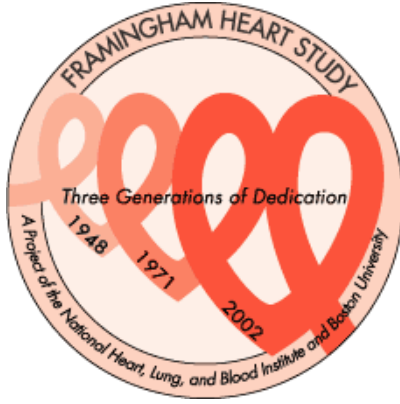
In the past week, about how many hours per day did you use a computer (for leisure time) or play computer games or play video games?

---

### Additional Comments

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#### Physical Activity Questionnaire - Leisurely Activities



## Framingham Heart Study

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### Physical Activity Questionnaire - Work Activities

☐ Form is intentionally left blank

Reason why form was left blank

Technician Number

Now, I'd like to ask you more about your physical activity at WORK ONLY.  
[In the past year...](#)

Do you work?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

In the past year...  
How many hours per week do you work?

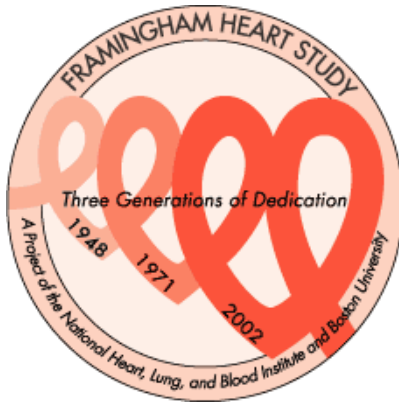
Number of hours,  
999 = Unknown

For seasonal workers - **Answer for the work you do most of the year.**

	Never (0 hrs)	Seldom	Sometimes	Often	Always	Do not recall
In the past year...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At work do you SIT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At work do you STAND	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At work do you WALK	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### Additional Comments

#### Physical Activity Questionnaire - Work Activities



# Framingham Heart Study

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## Respiratory Disease

☐ Form is intentionally left blank

Reason why form was left blank

Technician Number

### Respiratory Diagnoses

Since your last exam ([lastexamdate]). . .

Have you had asthma?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

<b>Do you still have asthma?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>Was the asthma diagnosed by a doctor or other health care professional?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>If asthma started since your last exam, at what age did it start?</b>	<input type="text"/> <small>Age in years, 888 = If asthma started before last exam, 999 = Unknown</small>
<b>If you no longer have asthma, at what age did it stop?</b>	<input type="text"/> <small>Age in years, 888 = Still have it, 999 = Unknown</small>
<b>Have you received medical treatment for this in the past 12 months?</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>Have you had any of the following conditions diagnosed by a doctor or other health care professional?</b>	
<b>Chronic Bronchitis</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>Emphysema</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>COPD (Chronic Obstructive Pulmonary Disease)</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>Sleep Apnea</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<b>Pulmonary Fibrosis</b>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

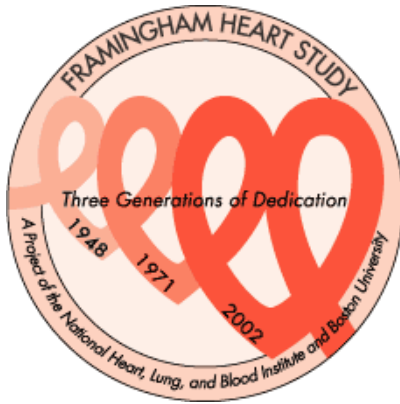
---

### Additional Comments

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#### Respiratory Disease





## Framingham Heart Study

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### Exit Interview and Adverse Events

☐ Form is intentionally left blank

Reason why form was left blank

Technician Number

#### Exit Interview

Removed and placed bar code label in chart?

- ☐ No
- ☐ Yes
- ☐ Bar code label not used
- ☐ Unknown

Referral sheet reviewed?

- ☐ No
- ☐ Yes
- ☐ Unknown

Dietary questionnaire brought to Research Center?	<input type="radio"/> No (refused or forgot to bring at time of exam) <input type="radio"/> Yes <input type="radio"/> Sent home <input type="radio"/> Unknown
<hr/>	
Left center with medications and belongings?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<hr/>	
Left center with accelerometer?	<input type="radio"/> No, refused <input type="radio"/> Yes <input type="radio"/> Mailed to participant <input type="radio"/> Unknown
<hr/>	
Left center with stool microbiome kit?	<input type="radio"/> No, refused <input type="radio"/> Yes <input type="radio"/> Mail <input type="radio"/> Unknown
<hr/>	
If "Yes" or "Mail"	
Microbiome id number	<input style="width: 350px; height: 20px;" type="text"/>
<hr/>	
<u>IPHONE</u> - Left center with eFHS app?	<input type="radio"/> No, refused <input type="radio"/> No, no iPhone <input type="radio"/> Yes <input type="radio"/> Will return later for set up <input type="radio"/> Unknown
<hr/>	
<u>ANDROID</u> - Left center with eFHS app?	<input type="radio"/> No, refused <input type="radio"/> No, no Android <input type="radio"/> Yes <input type="radio"/> Will return later for set up <input type="radio"/> Unknown
<hr/>	
Left center with TBI survey information?	<input type="radio"/> No, refused <input type="radio"/> Yes <input type="radio"/> Unknown
<hr/>	

---

**Feedback**  
Check all that apply and supply comments

---

☐ Feedback - NONE

---

☐ Feedback - POSITIVE

---

☐ Feedback - NEGATIVE

---

☐ Feedback - OTHER

---

### Adverse Events (not requiring further medical evaluation)

Technician Number

Was there an adverse event in clinic that does not require further medical evaluation?

- ☐ No
- ☐ Yes
- ☐ Unknown

Adverse Event comments

Technician who reviewed that all REDCap form questions were completed

### Additional Comments

Exit Interview and Adverse Events

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 your health care provider.

# Framingham Heart Study

Generation 3, NOS, Omni 2

## EXAM 3

### Research Center Questionnaire

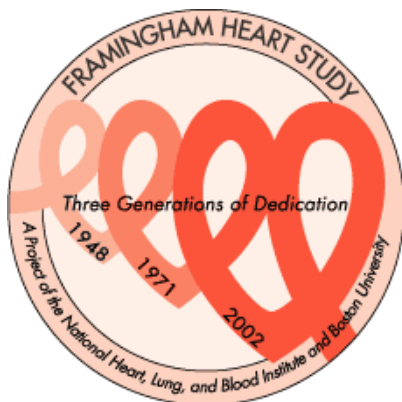
SECTIONS:

Admit	(pages 1 – 6) plus consents
MD	(pages 7 – 112)
Self-Administered Questions	(pages 113 – 142)
Tech	(pages 143 – 174)
Tonometry	(pages 175 – 177)

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## Tonometry Section





## Framingham Heart Study

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### Tonometry Worksheet

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#### Tonometry Worksheet Questions

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Have you had any caffeinated drinks in the last 6 hours?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

How many cups?

99 = Unknown

Have you eaten anything else including fat free pretzels this morning?

- ☐ No  
☐ Yes  
☐ Unknown

Have you smoked cigarettes in the last 6 hours?

- ☐ No  
☐ Yes  
☐ Unknown

If "Yes"

Example: 6 1/2 hours = 6 hours, 30 minutes

How many hours since your last cigarette? - hour portion

99 = Unknown

How many minutes since your last cigarette? - minute portion

99 = Unknown

### Tonometry Test Status

Tonometry Sonographer ID

Date of tonometry scan?

   M-D-Y

Was tonometry done?

- ☐ No, test was not attempted or done  
☐ Yes, test was done, even if all 4 pulses could not be acquired and recorded

If "No"

Reason why (check all that apply):

Subject refusal

☐ Yes

Subject discomfort

☐ Yes

Time constraint

☐ Yes

Equipment problem

☐ Yes

If "Yes"

Specify equipment problem

Other

☐ Yes

If "Yes"

Specify other problem

## Additional Comments

Tonometry Worksheet