

Framingham Heart Study

Offspring Exam 10

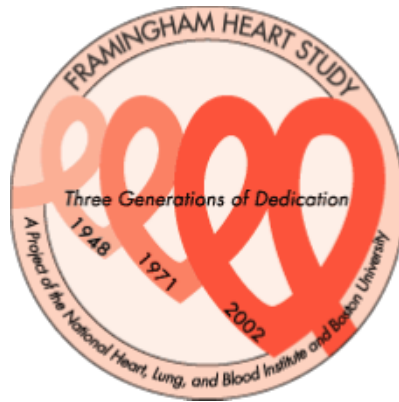
Omni 1 Exam 5

Research Center Questionnaire

SECTIONS:

Admit	(pages 1 – 4) plus consents
MD	(pages 5 – 118)
Self-Administered Questions	(pages 119 – 152)
Tech	(pages 153 – 224)
Tonometry	(pages 225 – 226)

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

31

Today

M-D-Y

Site

* must provide value

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

First name

Last name

Date of Birth

31

Today

M-D-Y

Additional Comments

Participant Information

Imported Validated Data for Data Management Use**Year of birth**[View equation](#)**Year of this FHS exam**[View equation](#)**Age (in years)**[View equation](#)**IDTYPE**☐ 1☐ 71 = Offspring,
7 = Omni Gen 1**ID**

FHS ID (4-digit)

Sex☐ Male☐ Female**Date of last exam**

Today

M-D-Y

Year of last exam[View equation](#)**Date of last medical health update**

Today

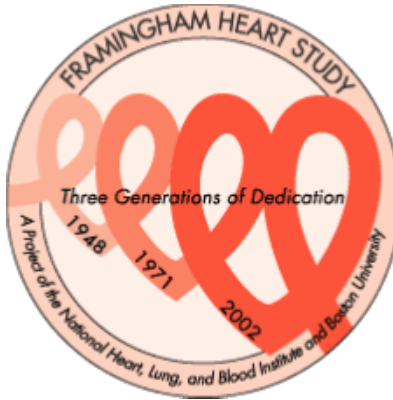
M-D-Y

Date of last medical information

Today

M-D-Y

Premenopausal**(using Exam 8 menopause dataset)**☐ No☐ Yes



Framingham Heart Study

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

Research Proxy

I, living at:

appoint the following person(s) to make decisions about my participation in the Framingham Heart Study ("Research Proxy"):

Research Proxy Name:

Relation:

Address:

City State Zip:

Home Phone:

Work Phone:

Other Phone:

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

Alternate Proxy Name:

Relation:

Address:

City State Zip:

Home Phone:

Work Phone:

Other Phone:

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:

  Today 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:

  Today M-D-Y

Address of Signer:

Witness Signature:

 [Add signature](#)

Witness Date:

  Today M-D-Y

Witness (2) Signature:

 [Add signature](#)

Witness (2) Date:

  Today M-D-Y



Project Title: The Framingham Heart Study
Principal Investigator: Vasana S. Ramachandran, MD

**Framingham Heart Study
Offspring Exam 10, Omni 1 Exam 5
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.

Basic Information

Title of Project: Framingham Heart Study

IRB Number: H-32132

Sponsor: National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH)

Principal Investigator: Vasana S. Ramachandran, MD
fhs@bu.edu
73 Mount Wayte Avenue, Suite 2
Framingham, MA 01702

Study Phone Number: (508) 872-6562 or (800) 854-7582

PI Phone Number: (617) 358-1310 for Dr. Vasana S Ramachandran

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?



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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 (800) 854-7582, or you can send an email to 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. Vasana S Ramachandran and Dr. Daniel Levy are in charge of the research study. You can contact Dr. Ramachandran at (617) 358-1310 Monday through Friday between 9am and 5pm or by email at vasan@bu.edu and Dr. Daniel Levy at (508) 935-3400 Monday to Friday between 9am and 5pm or by email at levy@nih.gov.

You may also call 617-358-5372 or email medirb@bu.edu. You will be talking to someone at the Boston Medical Center and Boston University Medical Campus IRB. The IRB is a group that helps monitor research. You should call or email the IRB if you want to find out about your rights as a research subject. You should also call or email if you want to talk to someone who is not part of the study about your questions, concerns, or problems.

What will happen in this research study?

You will need to fast for 10 hours before you come to the study appointment for the blood draw. You can continue to drink water while fasting and take your usual medication 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 4-5 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 up to 80mL, which is about 5.4 tablespoons. The blood draw will occur soon after your arrival.
- collect a urine sample
- measure your height, weight, and waist
- measure grip strength
- complete an electrocardiogram (ECG)
- record your blood pressure
- update your medical history information
- complete a test of cardiac vascular function (tonometry) that examines heart function using ultrasound scanning (echocardiogram) and tests blood vessel (artery) stiffness by recording the blood pressure and flow waveforms
- 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.



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- contact you later by mail, email, or by phone (call or text) 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. **Fibroscan:** We are interested in improving our understanding of the factors that can help predict the development of liver fat and liver fibrosis (scarring) for this study, you will have a test called a Fibroscan. The Fibroscan measures 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.

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 you to confirm if you have any of these conditions and if you do, we will not complete the Fibroscan.

2. **Pain Assessment Study:** We are interested in learning about pain people may be experiencing in their daily lives, and to better understand why some people have pain, more pain, or pain in more parts of their body, than other people do. We will ask some questions about pain and assess your sensitivity to pressure on your skin. To test your sensitivity to pressure, a small device will be pressed against a muscle on your shoulder to measure how much pressure is applied before you feel any discomfort.

What risks can I expect? Although rare, there is the potential for skin irritation and redness or bruising during testing. Bruising or discomfort could potentially result from application of the pressure meter during pressure pain threshold testing and/or blood pressure cuff inflation.

3. **Brain Health Study:** We are interested in finding a way to define brain health beyond the evaluation of cognitive testing. We will ask you to participate in a number of sensory motor tests that capture your brain health, including testing your vision, hearing, balance, and motor function. You will have eye testing (without dilatation); balance testing (standing on foam with eyes closed, aligning a line vertically, fixing your eyes on a target



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or reading while your head is being moved); hearing testing (using an iPad and headphones); and physical function testing (includes gait speed assessment on an electronic gait mat, during normal walk and while doing a mental task like counting and timed chair stands).

What risk can I expect? There are no risks involved in eye and hearing testing. Balance testing and gait testing have a minimal risk of falling. All precautions will be taken to prevent falls. A study staff member will stand near you to prevent you from falling and help you if needed.

Some of the study components described in this section "What will happen in this research study?" may not be administered during offsite examinations taking place at your home or care facility, due to large equipment that cannot be transported outside of the research center. For example, Fibroscan and Tonometry.

Overall Examination Risks and Discomforts

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

You may have already provided consent for the collection of biological samples for DNA research or the creation of Induced Pluripotent Stem Cells (iPS cells). We plan to continue to do genetic research on the DNA from your biological samples. The biological samples include blood cells, tissue cells, 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.



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- 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 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. In the cases when genetic research findings are reported to you, a study investigator and genetic counselor will contact you to confirm your continued interest in hearing about genetic research results. If you confirm your interest, the study staff will inform you of the research results and recommend next steps such as obtaining confirmatory clinical testing and speaking with your personal healthcare provider.



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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, 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. The cell/tissue storage banks and repositories, databanks and data repositories, include but are not limited to, NIH repositories dbGaP and BioLINCC. Internal and external researchers may request data and materials for research. The repositories have standard operating procedures to protect your confidentiality. Your data and samples 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?

General risks and individual risks related to new activities are discussed above.

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.



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There is a potential risk that your genetic information could be used to your disadvantage. For example, if genetic research findings suggest a serious health problem, that could be used to make it harder for you to get or keep a job or insurance. Both Massachusetts state laws and federal laws, particularly the Genetic Information Nondiscrimination Act (GINA), generally make it illegal for health insurance companies, group health plans, and most employers to discriminate against you based on your genetic information. These laws will generally protect you in the following ways:

1. Health insurance companies and group health plans may not request your genetic information that we get from this research.
2. Health insurance companies and group health plans may not use your genetic information when making decisions regarding your eligibility or premiums.
3. Massachusetts employers with 6 or more employees (or 15 or more employees in other states, under GINA) may not use your genetic information that we get from this research when making a decision to hire, promote, or fire you or when setting the terms of your employment.

Be aware that neither Massachusetts law nor GINA protects you against genetic discrimination by companies that sell life insurance, disability insurance, or long-term care insurance. Thus, life insurance, disability insurance, and long-term care insurance companies may legally ask whether you have had genetic testing and deny coverage for refusal to answer this question.

How is my information protected?

We will store your information in ways we think are 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.

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 provide 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).

This study is covered by a Certificate of Confidentiality (CoC) from the National Institutes of Health. All studies funded by the National Institutes of Health that involve identifiable information or biological samples are covered by a CoC. The CoC provides how we can share research



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information or biological samples. Because we have a CoC, we cannot give out research information or biological samples that may identify you to anyone that is not involved in the research except as we describe below. Even if someone tries to get your information or biological samples in connection with a legal proceeding, we cannot give it to them. The CoC does not prevent you from sharing your own research information.

If you agree to be in the study and sign this form, we will share information and biological samples that may show your identity with the following groups of people:

- People who do the research or help oversee the research, including safety monitoring.
- People from Federal and state agencies who audit or review the research, as required by law. Such agencies may include the U.S. Department of Health and Human Services, the Food and Drug Administration, the National Institutes of Health, and the Massachusetts Department of Public Health.
- Investigators who will get your data and your biological samples as we described in the section "*What will happen in this research study?*" These people are expected to protect your information and biological samples in the same way we protect it.
- Any people who you give us separate permission to share your information.

You should know that we are required to report information about child abuse or neglect; elder abuse; specific reportable diseases; or harm to others.

We will share research data where we have removed anything that we think would show your identity. There still may be a small chance that someone could figure out that the information is about you. Such sharing includes:

- Publishing results in a medical book or journal.
- Adding results to a Federal government database
- Using research data in future studies, done by us or by other scientists.
- Using biological samples in future studies, done by us or by other scientists.

Samples that are collected from you in this study will be analyzed to find out information about your genetic makeup. Your genetics and health information, without your name or other data that could easily identify you, will be put in a database run by the National Institutes of Health (NIH). This may include your whole genome information. Other researchers can ask the NIH to get your information from the database. You should know that it is possible that your genetics information might be used to identify you or your family, though we believe it is not too likely that this will happen. Once your information is given to the NIH database, you can ask to have NIH stop sharing it, but NIH cannot take back information that was already shared.

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?



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While you will not receive any direct benefit 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.

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.).

You will not be paid for your participation in this study.

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.

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.

* must provide value

☐ Yes ☐ No

(For Internal Use - Office Code 0

[reset](#)

2) 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.

* must provide value

☐ Yes ☐ No

(For Internal Use - Office Code 3

[reset](#)

3) 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.

* must provide value

☐ Yes ☐ No

(For Internal Use - Office Code 4

[reset](#)

4) 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.

* must provide value

☐ Yes ☐ No

(For Internal Use - Office Code 30

[reset](#)

5) 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.

* must provide value

☐ Yes ☐ No

(For Internal Use - Office Code 31

[reset](#)

BMC and BU Medical Campus IRB

IRB NUMBER: H-32132

IRB APPROVAL DATE: 11/21/2019

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Res.v19

Subject: [firstname], [lastname]

By signing this consent form, you are indicating that

- you have read this form (or it has been read to you)
- your questions have been answered to your satisfaction
- you voluntarily agree to participate in this research study
- you permit the use and sharing of information that may identify you as described, including your health information.

To be completed by subject if personally signing

Signature of subject

[+ Add signature](#)

Date completed by subject if personally signing

Participants Signature

  Today M-D-Y

To be completed by LAR if subject does not personally sign

I am providing consent on behalf of the subject.

Printed name of Legally Authorized Representative (LAR)

Relationship to Subject

- ☐ Spouse/partner
☐ Family member other than spouse
☐ Friend
☐ Healthcare provider
☐ Other

[reset](#)

If relationship is "Other" please specify:

Signature of Legally Authorized Representative

[+ Add signature](#)

Date completed by LAR if subject does not personally sign

LAR Signature

  Today M-D-Y

Researcher:

Printed name of person conducting consent discussion

* must provide value

Use dropdown for your Name and Signature

To be completed by researcher if subject personally signs

I have personally explained the research to the above-named subject and answered all questions. I believe that the subject understands what is involved in the study and freely agrees to participate.

Date Researcher signed consent:

* must provide value

  Today M-D-Y

To be completed by researcher if subject does not personally sign

I have personally explained the research to the above-named subject's Legally Authorized Representative and answered all questions. I believe that the Legally Authorized Representative understands what is involved in the study and freely agrees to have the subject participate.

I consider that the above-named subject (check one):

- ☐ Is capable of understanding what is involved in the study and freely agrees to participate
☐ Is not capable of understanding what is involved in the study

[reset](#)

Signature of person conducting consent discussion

Use dropdown for your Name and Signature

Date of person conducting consent discussion

  Today M-D-Y

Comments for consents

Expand

BMC and BU Medical Campus IRB

IRB NUMBER: H-32132

IRB APPROVAL DATE: 11/21/2019

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Res.v19

Framingham Heart Study

Offspring Exam 10

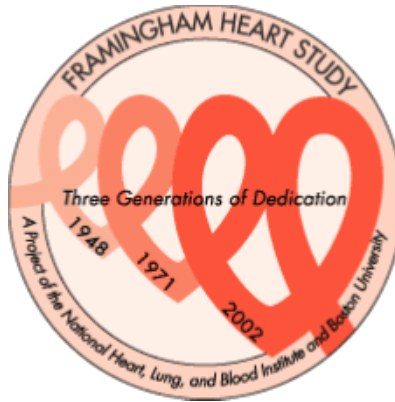
Omni 1 Exam 5

Research Center Questionnaire

SECTIONS:

Admit	(pages 1 – 4) plus consents
MD	(pages 5 – 118)
Self-Administered Questions	(pages 119 – 152)
Tech	(pages 153– 224)
Tonometry	(pages 225 – 226)

MD Section



Framingham Heart Study

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

Medical Encounters

1st Examiner ID

Form is intentionally left blank

- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

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

1971-2022,
9999 = Unknown

DATE details

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

Name of hospital**Location of hospital**

City, State

Check here for additional comments☐ Yes**Have you had another hospitalization?**

- ☐ No
☐ Yes
☐ Unknown

If "Yes"**Hospitalization #2****Reason****Year**1971-2022,
9999 = Unknown**DATE details**

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

Name of hospital**Location of hospital**

City, State

Check here for additional comments☐ Yes**Have you had another hospitalization?**

- ☐ No
☐ Yes
☐ Unknown

If "Yes"**Hospitalization #3****Reason****Year**1971-2022,
9999 = Unknown

DATE details

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

Name of hospital

Location of hospital

City, State

Check here for additional comments

☐ Yes

Have you had another hospitalization?

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Hospitalization #4

Reason

Year

1971-2022,
9999 = Unknown

DATE details

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

Name of hospital

Location of hospital

City, State

Check here for additional comments

☐ Yes

Have you had another hospitalization?

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Hospitalization #5

Reason

Year1971-2022,
9999 = Unknown**DATE details**

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

Name of hospital**Location of hospital**

City, State

Check here for additional comments☐ Yes**If participant has had more than 5 hospitalizations, provide details in "Additional Comments" below.****E.R. visits only?**

- ☐ No
☐ Yes
☐ Unknown

If "Yes"**E.R. Visit #1****Reason****Year**1971-2022,
9999 = Unknown**DATE details**

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

Name of hospital**Location of hospital**

City, State

Check here for additional comments☐ Yes**Have you had another E.R. visit?**

- ☐ No
☐ Yes
☐ Unknown

If "Yes"**E.R. Visit #2**

Reason**Year**1971-2022,
9999 = Unknown**DATE details**

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

Name of hospital**Location of hospital**

City, State

Check here for additional comments☐ Yes**Have you had another E.R. visit?**

- ☐ No
☐ Yes
☐ Unknown

If "Yes"**E.R. Visit #3****Reason****Year**1971-2022,
9999 = Unknown**DATE details**

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

Name of hospital**Location of hospital**

City, State

Check here for additional comments☐ Yes**Have you had another E.R. visit?**

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

E.R. Visit #4**Reason****Year**1971-2022,
9999 = Unknown**DATE details**

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

Name of hospital**Location of hospital**

City, State

Check here for additional comments☐ Yes**Have you had another E.R. visit?**

- ☐ No
☐ Yes
☐ Unknown

If "Yes"**E.R. Visit #5****Reason****Year**1971-2022,
9999 = Unknown**DATE details**

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

Name of hospital**Location of hospital**

City, State

Check here for additional comments☐ Yes**If participant has had more than 5 E.R. visits, provide details in "Additional Comments" below.**

Day surgery?

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Day Surgery #1

Reason

Year

1971-2022,
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

Check here for additional comments

☐ Yes

Have you had another day surgery?

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Day Surgery #2

Reason

Year

1971-2022,
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

Check here for additional comments

☐ Yes

Have you had another day surgery?

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Day Surgery #3

Reason

Year

1971-2022,
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

Check here for additional comments

☐ Yes

Have you had another day surgery?

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Day Surgery #4

Reason

Year

1971-2022,
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

[Check here for additional comments](#)☐ Yes

Have you had another day surgery?

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Day Surgery #5

Reason

Year

1971-2022,
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

[Check here for additional comments](#)☐ Yes

If participant has had more than 5 day surgeries, provide details in "Additional Comments" below.

Major illness with visit to doctor?

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Major Illness #1

Reason

Year

1971-2022,
9999 = Unknown

DATE details

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

Name of doctor

Doctor's office location

City, State

Check here for additional comments

☐ Yes

Have you had another major illness with visit to doctor?

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Major Illness #2

Reason

Year

1971-2022,
9999 = Unknown

DATE details

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

Name of doctor

Doctor's office location

City, State

Check here for additional comments

☐ Yes

Have you had another major illness with visit to doctor?

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Major Illness #3

Reason

Year

1971-2022,
9999 = Unknown

DATE details

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

Name of doctor**Doctor's office location**

City, State

Check here for additional comments☐ Yes**Have you had another major illness with visit to doctor?**

- ☐ No
☐ Yes
☐ Unknown

If "Yes"**Major Illness #4****Reason****Year**1971-2022,
9999 = Unknown**DATE details**

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

Name of doctor**Doctor's office location**

City, State

Check here for additional comments☐ Yes**Have you had another major illness with visit to doctor?**

- ☐ No
☐ Yes
☐ Unknown

If "Yes"**Major Illness #5****Reason****Year**1971-2022,
9999 = Unknown

DATE details

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

Name of doctor

Doctor's office location

City, State

Check here for additional comments

☐ Yes

If participant has had more than 5 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

1971-2022,
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

Check here for additional comments

☐ Yes

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

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Checkup or office visit #2

Reason

Year

1971-2022,
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

Check here for additional comments

☐ Yes

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

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Checkup or office visit #3

Reason

Year

1971-2022,
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

Check here for additional comments

☐ Yes

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

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Checkup or office visit #4

Reason**Year**1971-2022,
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

Check here for additional comments☐ Yes**Have you had another checkup or office visit with doctor or other health care provider?**

- ☐ No
☐ Yes
☐ Unknown

If "Yes"**Checkup or office visit #5****Reason****Year**1971-2022,
9999 = Unknown**DATE details**

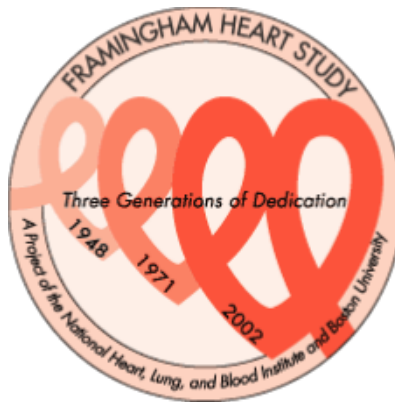
(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Name of hospital or doctor**Location of hospital or doctor**

City, State

Check here for additional comments☐ Yes**If participant has had more than 5 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

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

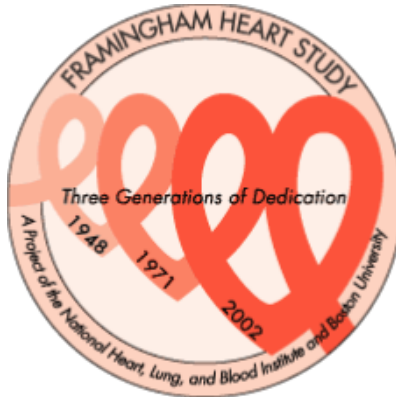
Cardiovascular Disease

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

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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 M02

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**

Medication name #21

Medication name #22

Medication name #23

Medication name #24

Medication name #25

Medication name #26

Medication name #27

Medication name #28

Medication name #29

Medication name #30

NOTE: If 'YES' taking medication, please answer ['medications not found on the drop down list'](#) below

Are there any medications that you could not find on the drop down list (code aspirin only on prior page M02)?

- ☐ 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

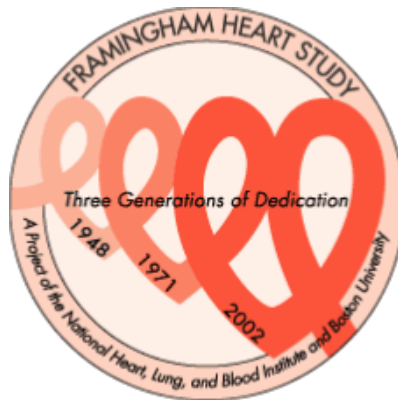
Have you received an influenza vaccine (aka "flu shot") within the last year?

- ☐ 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 Reproduction History - Menopause and Surgery

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

Menopause

What is the best way to describe your periods?

(Check the BEST answer)

- ☐ Not stopped
- ☐ Periods stopped due to pregnancy, breast feeding, or hormonal contraceptive (for example: depo-provera, progestin releasing IUD, extended release birth control pill)
- ☐ Periods stopped due to low body weight, heavy exercise, or due to medication or health condition such as thyroid disease, pituitary tumor, hormone imbalance, stress
- ☐ Periods stopped for less than 1 year (perimenopausal)
- ☐ Periods stopped for 1 year or more
- ☐ Periods stopped, but now have periods induced by hormones

Write in CAUSE why periods stopped

NUMBER OF MONTHS since last period

99=Unknown

NUMBER OF MONTHS periods stopped before hormones started

99 = Unknown

WHEN was the first day of your last menstrual period?
(If first day of last menstrual period is unknown, enter 1/1/1900)

  Today M-D-Y

1/1/1900 = Unknown

HOW MANY periods have you had in past 12 months?

99=Unknown

AGE when periods stopped

(If periods now induced by hormones, code age when periods naturally stopped. If perimenopausal, code age when periods stopped or became irregular.)

99=Unknown

Was your menopause natural or the result of surgery, chemotherapy, or radiation?

(If periods stopped for less than a year choose best answer.)

- ☐ Natural
- ☐ Surgical
- ☐ Chemo or radiation
- ☐ Other
- ☐ Unknown

Have you since your last exam ([lastexamdate]) taken HORMONE REPLACEMENT THERAPY (estrogen or progesterone) or a selective estrogen receptor modulator (such as evista or raloxifene)?

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

Surgery History

Since your last exam ([lastexamdate]) have you had a hysterectomy (uterus or womb removed)?

- ☐ No
- ☐ Yes
- ☐ Unknown

If "Yes"

Age at hysterectomy?

99=Unknown

Date of hysterectomy - Year

no lower limit - 2022,
9999 = Unknown

Date of hysterectomy - Month

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.)

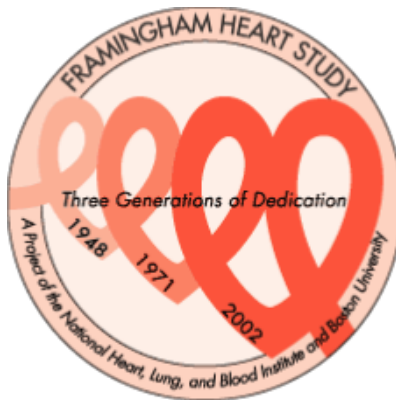
99=Unknown

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?

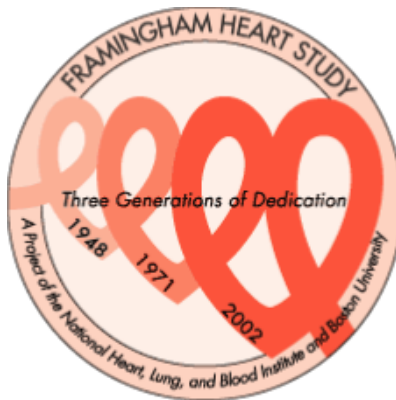
of days per week,
1 = 1 day or less per week,
9 = Unknown

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 or more days
☐ Refused to answer
☐ Don't know

Additional Comments

Smoking



Framingham Heart Study

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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

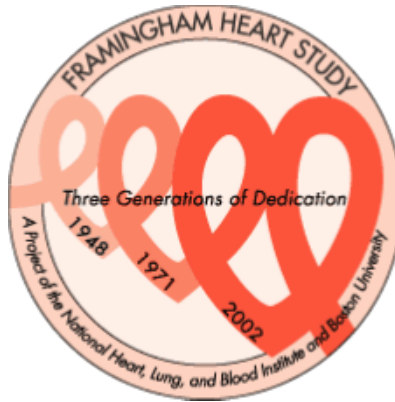
Examiner Opinion:

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

Do you usually have a cough?
- Exclude clearing of the throat

- ☐ No
- ☐ Yes
- ☐ Unknown

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

- ☐ No
- ☐ Yes
- ☐ Unknown

If "Yes" to either of the two questions directly above

Do you cough like this on most days for three consecutive months or more during the past year?

- ☐ No
- ☐ Yes
- ☐ Unknown

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?

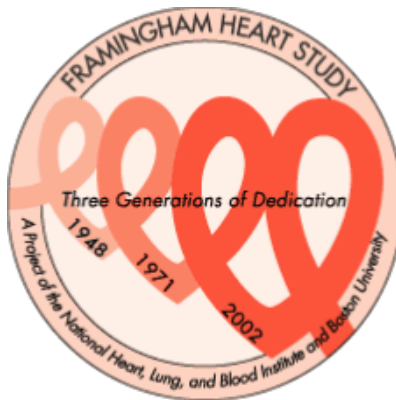
- ☐ No
☐ Yes
☐ Unknown

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

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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

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

Doctor's office location

City, state

Date of visit - year1971-2022,
9999 = Unknown**DATE details**

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

Check here for additional comments☐ Yes**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 - year1971-2022,
9999 = Unknown**DATE details**

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

Check here for additional comments☐ Yes

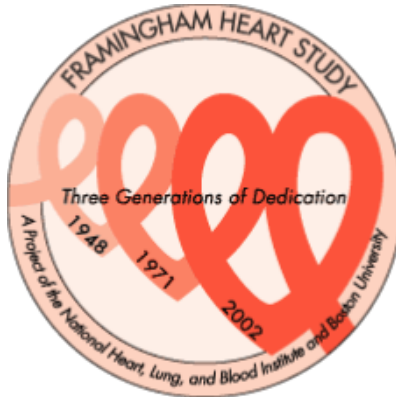
CHF First Examiner Opinion

First Examiner believes CHF

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

Additional Comments

Sleep Apnea and CHF Opinion



Framingham Heart Study

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

Blood Pressure 1st MD/Nurse Practitioner 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)

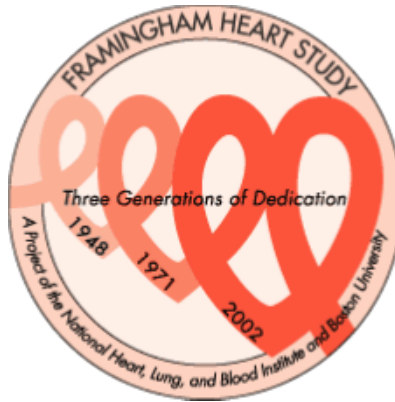
999 = Unknown

Diastolic (to nearest 2 mmHg)

999 = Unknown

Additional Comments

Blood Pressure 1st MD/Nurse Practitioner Reading



Framingham Heart Study

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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

1971-2022,
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

Radiation

Number of episodes of chest pain in past month

999 = Unknown

Number of episodes of chest pain in past year

999 = Unknown

Type

- ☐ Pressure, heavy, vise
- ☐ Sharp
- ☐ Dull
- ☐ Other
- ☐ Unknown

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

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

Have you been told by a doctor you had 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 doctor

Doctor's office location

City, State

Date of visit - year

1971-2022,
9999 = Unknown

DATE details

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

[Check here for additional comments](#)☐ Yes**Since you last provided medical information ([lastmedinfodate])...****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 - year1971-2022,
9999 = Unknown**DATE details**

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

[Check here for additional comments](#)☐ Yes**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

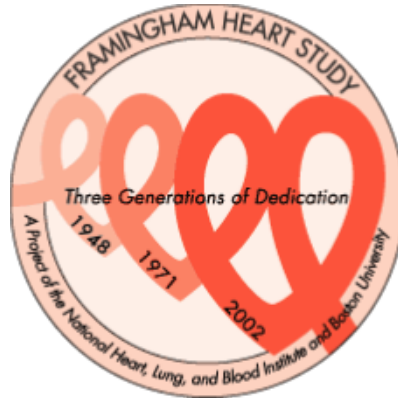
- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

Myocardial infarct

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

Additional Comments

Chest Discomfort and CHD Opinion



Framingham Heart Study

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Atrial Fibrillation, Syncope & Syncope Opinion

Atrial Fibrillation

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]

1971-2022,
8888 = If first episode started before [lastmedinfodate]
9999 = Unknown

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

8888 = If first episode started before [lastmedinfodate]

For the atrial fibrillation questions below, please code procedures and events since [lastmedinfodate]

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

Doctor's office location

City, State

Year

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

- ☐ Yes

Have you had a cardioversion for your atrial fibrillation or flutter?

- ☐ 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

Name of doctor

Doctor's office location

City, State

Year

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

- ☐ Yes

Have you had a cardiac ablation (e.g. cryoablation, pulmonary vein isolation, PVI, cavo-tricuspid isthmus ablation) for your atrial fibrillation or flutter?

- ☐ 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

Name of doctor

Doctor's office location

City, State

Year

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

- ☐ Yes

Have you had a surgical cardiac ablation (e.g. Maze procedure) for your atrial fibrillation or flutter?

- ☐ 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

Name of doctor

Doctor's office location

City, State

Year

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

☐ Yes

Have you had an AV node ablation to treat your atrial fibrillation or flutter?

- ☐ 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

Name of doctor

Doctor's office location

City, State

Year

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

☐ Yes

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]**

 1971-2022,
 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 doctor

Doctor's office location

City, State

Year

 1971-2022,
 9999 = Unknown
DATE details

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

Check here for additional comments

- ☐ Yes

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"

Name of hospital

Location of hospital

Name of doctor

Doctor's office location

Year

1971-2022,
9999 = Unknown

DATE details

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

[Check here for additional comments](#)

☐ Yes

Have you had a seizure?

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

If "Yes" or "Maybe"

Did you bite your tongue, lose urine, or stool during the event?

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

Year of most recent seizure since [lastmedinfo date]

1971-2022,
9999 = Unknown

DATE details

(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

Doctor's office location

City, State

Year

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

- ☐ Yes

Are you being treated for a seizure disorder?

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ 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

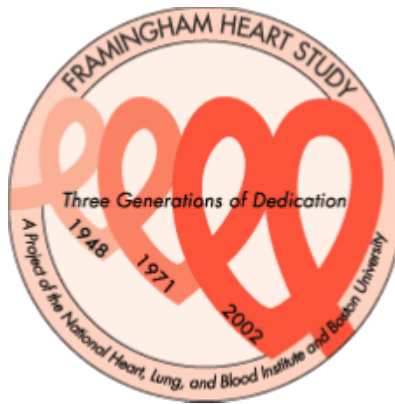
Other syncope

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

Specify other syncope

Additional Comments

Atrial Fibrillation, Syncope & Syncope Opinion



Framingham Heart Study

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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"

Reason for Head CT

Have medical encounter details been entered on M01
 Medical Encounters?

- ☐ No
☐ Yes

If "No"

Name of facility

Location of facility

City, State

Date - year

1971-2022,
 9999 = Unknown

DATE details

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

Check here for additional comments

- ☐ Yes

HEAD MRI scan OTHER THAN FOR THE FHS

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

If "Yes" or "Maybe"

Reason for Head MRI

Have medical encounter details been entered on M01
 Medical Encounters?

- ☐ No
☐ Yes

If "No"

Name of facility

Location of facility

City, State

Date - year

1971-2022,
 9999 = Unknown

DATE details

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

Check here for additional comments

- ☐ Yes

Seen by neurologist

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

If "Yes" or "Maybe"

Reason for seeing a neurologist

Have medical encounter details been entered on M01
Medical Encounters?

- ☐ No
☐ Yes

If "No"

Name of neurologist

Location of neurologist

City, State

Date - year

1971-2022,
9999 = Unknown

DATE details

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

[Check here for additional comments](#)

- ☐ Yes

	No	Yes	Maybe	Unknown
Have you been told by a doctor you had a STROKE or TIA (transient ischemic attack, mini-stroke)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you been told by a doctor you have PARKINSON'S disease?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you been told by a doctor you have MEMORY problems, DEMENTIA or ALZHEIMER'S disease?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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?

☐☐☐☐

Do you feel your memory is becoming WORSE?

☐☐☐☐

Cerebrovascular Disease First Examiner Opinion

TIA or STROKE took place

☐ No

☐ Yes

☐ Maybe

☐ Unknown

If "Yes" or "Maybe"

Date of TIA or STROKE - year

1971-2022,
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

Doctor's office location

City, State

Date - year

1971-2022,
9999 = Unknown

DATE details

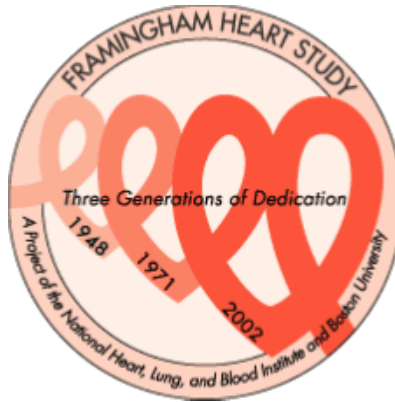
(e.g. 10/2, April, Summer, August-Nov., Unknown etc.)

Check here for additional comments

☐ Yes

Additional Comments

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

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

Name of doctor

Doctor's office location

City, state

Date of visit - year

1971-2022,

9999 = Unknown

DATE details

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

Check here for additional comments☐ Yes**Pulmonary embolus - PE (blood clot in lungs)**

- ☐ 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

Name of doctor**Doctor's office location**

City, state

Date of visit - year1971-2022,
9999 = Unknown**DATE details**

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

Check here for additional comments☐ Yes**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?

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

(where 10 blocks = 1 mile)

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

Doctor's office location

City, State

Date of visit - year

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

- ☐ Yes

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

- ☐ No
☐ Yes
☐ Unknown

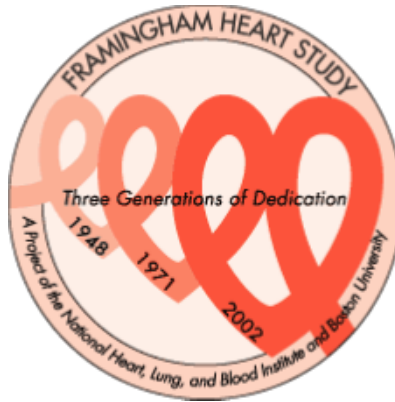
Intermittent Claudication First Examiner Opinion

Intermittent claudication

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

Additional Comments

Venous and Peripheral Arterial Disease and Intermittent Claudication Opinion



Framingham Heart Study

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CVD Procedures

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

Did you have any of the following cardiovascular procedures?

Heart valvular surgery

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Heart valvular surgery

1971-2022,
9999 = Unknown

DATE details

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

[Check here for additional comments](#)☐ Yes

Did you have another heart valvular surgery?

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Heart valvular surgery

1971-2022,
9999 = Unknown

DATE details

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

[Check here for additional comments](#)☐ Yes

Exercise stress test or other type of cardiac stress test

- ☐ 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

Name of doctor**Doctor's office location**

City, state

YEAR - Exercise stress test1971-2022,
9999 = Unknown**DATE details**

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

Check here for additional comments☐ Yes**Did you have another exercise stress test or other type of cardiac stress test?**

- ☐ 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

Name of doctor**Doctor's office location**

City, state

YEAR - Exercise stress test1971-2022,
9999 = Unknown**DATE details**

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

Check here for additional comments☐ Yes

Coronary arteriogram

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Coronary arteriogram

1971-2022,
9999 = Unknown

DATE details

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

[Check here for additional comments](#)

- ☐ Yes

Did you have another coronary arteriogram?

- ☐ 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

City, state

Location of hospital

City, state

Name of doctor

Doctor's office location

YEAR - Coronary arteriogram

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments☐ Yes**Coronary artery angioplasty or stent**

- ☐ 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

Name of doctor**Doctor's office location**

City, state

YEAR - Coronary artery angioplasty or stent1971-2022,
9999 = Unknown**DATE details**

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

Check here for additional comments☐ Yes

Did you have another coronary artery angioplasty or stent?

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Coronary artery angioplasty or stent

1971-2022,
9999 = Unknown

DATE details

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

[Check here for additional comments](#)

☐ Yes

Coronary bypass surgery

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Coronary bypass surgery

1971-2022,
9999 = Unknown

DATE details

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

[Check here for additional comments](#)

☐ Yes

Did you have another coronary bypass surgery?

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Coronary bypass surgery

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

- ☐ Yes

Permanent pacemaker insertion

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Permanent pacemaker insertion

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

☐ Yes

Did you have another permanent pacemaker insertion?

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Permanent pacemaker insertion

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

☐ Yes

Carotid artery surgery or stent

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Carotid artery surgery or stent

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

- ☐ Yes

Did you have another carotid artery surgery or stent?

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Carotid artery surgery or stent

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

☐ Yes

Thoracic aorta surgery

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Thoracic aorta surgery

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

☐ Yes

Did you have another thoracic aorta surgery?

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Thoracic aorta surgery

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments☐ Yes

Abdominal aorta surgery

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Abdominal aorta surgery

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments☐ Yes

Did you have another abdominal aorta surgery?

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Abdominal aorta surgery

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

- ☐ Yes

Femoral or lower extremity surgery

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Femoral or lower extremity surgery

1971-2022,
9999 = Unknown

DATE details

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

[Check here for additional comments](#)☐ Yes

Did you have another femoral or lower extremity surgery?

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Femoral or lower extremity surgery

1971-2022,
9999 = Unknown

DATE details

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

[Check here for additional comments](#)☐ Yes

Lower extremity amputation

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Lower extremity amputation

1971-2022,
9999 = Unknown

DATE details

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

[Check here for additional comments](#)

- ☐ Yes

Did you have another lower extremity amputation?

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Lower extremity amputation

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

☐ Yes

Other cardiovascular procedure (specify below)

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Other cardiovascular procedure

1971-2022,
9999 = Unknown

DATE details

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

Check here for additional comments

☐ Yes

Specify other cardiovascular procedure

Did you have another other cardiovascular procedure (specify below)?

- ☐ 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

Name of doctor

Doctor's office location

City, state

YEAR - Other cardiovascular procedure

1971-2022,
9999 = Unknown

DATE details

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

[Check here for additional comments](#)

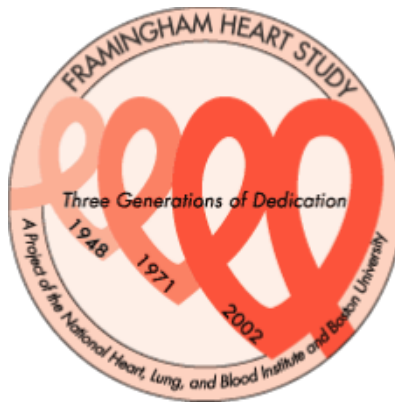
☐ Yes

Specify other cardiovascular procedure

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

Additional Comments

CVD Procedures



Framingham Heart Study

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

Blood Pressure 2nd MD/Nurse Practitioner Reading

BP cuff size

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

Protocol modification

- ☐ No
- ☐ Yes
- ☐ Unknown

If "Yes"

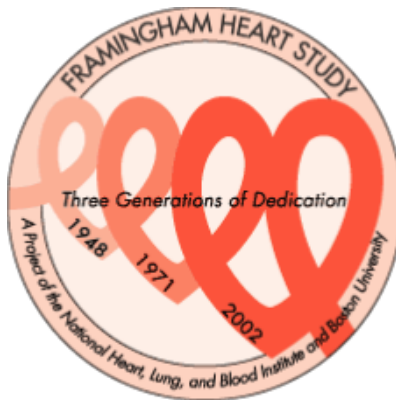
Comments for protocol modification

Systolic (to nearest 2 mmHg)

Diastolic (to nearest 2 mmHg)

Additional Comments

Blood Pressure 2nd MD/Nurse Practitioner Reading



Framingham Heart Study

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Cancer

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

1971-2022,
9999 = Unknown

DATE details - #1 ([cancersite1])

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

Name of doctor - #1 ([cancersite1])

Doctor's office location - #1 ([cancersite1])

City, State

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

- ☐ No
- ☐ Yes

If "Yes"**Year of biopsy - #1 ([cancersite1])**

1971-2022,
9999 = Unknown

DATE details for biopsy - #1 ([cancersite1])

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

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

Location of biopsy - #1 ([cancersite1])

City, State

Have you had a second cancer or tumor?

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

If "Yes" or "Maybe"

Cancer or tumor - #2

- ☐ 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" - #2 ([cancersite2])

Diagnosis - #2 ([cancersite2])

- ☐ Cancer
☐ Maybe cancer
☐ Benign

Have medical encounter details been entered on M01 Medical Encounters - #2 ([cancersite2])

- ☐ No
☐ Yes

If "No"

Year first diagnosed - #2 ([cancersite2])

1971-2022,
9999 = Unknown

DATE details - #2 ([cancersite2])

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

Name of doctor - #2 ([cancersite2])

Doctor's office location - #2 ([cancersite2])

City, State

Was a diagnostic biopsy done at a different location? - #2 ([cancersite2])

- ☐ No
☐ Yes

If "Yes"

Year of biopsy - #2 ([cancersite2])

1971-2022,
9999 = Unknown

DATE details for biopsy - #2 ([cancersite2])

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

Name of doctor for biopsy - #2 ([cancersite2])**Location of biopsy - #2 ([cancersite2])**

City, State

Have you had a third cancer or tumor?

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

If "Yes" or "Maybe"**Cancer or tumor - #3**

- ☐ 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" - #3 ([cancersite3])**Diagnosis - #3 ([cancersite3])**

- ☐ Cancer
☐ Maybe cancer
☐ Benign

Have medical encounter details been entered on M01 Medical Encounters - #3 ([cancersite3])

- ☐ No
☐ Yes

If "No"**Year first diagnosed - #3 ([cancersite3])**1971-2022,
9999 = Unknown**DATE details - #3 ([cancersite3])**

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

Name of doctor - #3 ([cancersite3])**Doctor's office location - #3 ([cancersite3])**

City, State

Was a diagnostic biopsy done at a different location? - #3 ([cancersite3])

- ☐ No
☐ Yes

If "Yes"

Year of biopsy - #3 ([cancersite3])

1971-2022,
9999 = Unknown

DATE details for biopsy - #3 ([cancersite3])
(e.g. 10/2, April, Summer, August-Nov., Unknown etc)

Name of doctor for biopsy - #3 ([cancersite3])

Location of biopsy - #3 ([cancersite3])

City, State

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

Have you had a fourth cancer or tumor?

If "Yes" or "Maybe"

- ☐ 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 - #4

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])

1971-2022,
9999 = Unknown

DATE details - #4 ([cancersite4])

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

Name of doctor - #4 ([cancersite4])

Doctor's office location - #4 ([cancersite4])

City, State

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

- ☐ No
☐ Yes

If "Yes"

Year of biopsy - #4 ([cancersite4])

1971-2022,
9999 = Unknown

DATE details for biopsy - #4 ([cancersite4])

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

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

Location of biopsy - #4 ([cancersite4])

City, State

Have you had a fifth cancer or tumor?

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

If "Yes" or "Maybe"

- ☐ 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 - #5

Cancer or tumor site for "Other" - #5 ([cancersite5])

Diagnosis - #5 ([cancersite5])

- ☐ Cancer
☐ Maybe cancer
☐ Benign

Have medical encounter details been entered on M01
Medical Encounters - #5 ([cancersite5])

☐ No
☐ Yes

If "No"

Year first diagnosed - #5 ([cancersite5])

1971-2022,
9999 = Unknown

DATE details - #5 ([cancersite5])

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

Name of doctor - #5 ([cancersite5])

Doctor's office location - #5 ([cancersite5])

City, State

Was a diagnostic biopsy done at a different
location? - #5 ([cancersite5])

☐ No
☐ Yes

If "Yes"

Year of biopsy - #5 ([cancersite5])

1971-2022,
9999 = Unknown

DATE details for biopsy - #5 ([cancersite5])

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

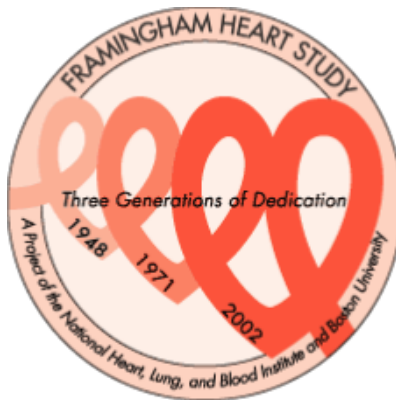
Name of doctor for biopsy - #5 ([cancersite5])

Location of biopsy - #5 ([cancersite5])

City, State

Additional Comments

Cancer



Framingham Heart Study

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ECG

Check if ECG not done

☐ ECG not done

If "ECG not done"

Reason ECG not done

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/Nurse Practitioner 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

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

Hypertrophy, Enlargement, and Other ECG Diagnoses

Nonspecific S-T segment abnormality

- ☐ No
- ☐ S-T depression
- ☐ S-T flattening
- ☐ Other
- ☐ Fully paced or Unknown

Nonspecific T-wave abnormality

- ☐ No
- ☐ T inversion
- ☐ T flattening
- ☐ Other
- ☐ Fully paced or Unknown

Atrial enlargement

- ☐ None
- ☐ Left
- ☐ Right
- ☐ Both
- ☐ Atrial fibrillation or Unknown

RVH

**If complete RBBB or LBBB present,
code RVH = Unknown**

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

LVH

**If complete LBBB present,
code LVH = Unknown**

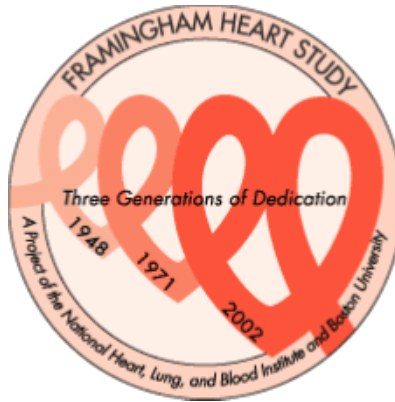
LVH VOLTAGE CRITERIA

- 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

- ☐ No
- ☐ LVH with strain
- ☐ LVH with mild S-T segment abnormality
- ☐ LVH by voltage only
- ☐ Fully paced or Unknown

Additional Comments

ECG



Framingham Heart Study

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Review of Health History Based on Examiner Interview

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

Expand

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	<input type="text"/>			

GU/ GYN

	No	Yes	Maybe	Unknown
Renal disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify renal disease	<input type="text"/>			
Prostate disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gynecological problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify gynecological problems	<input type="text"/>			

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

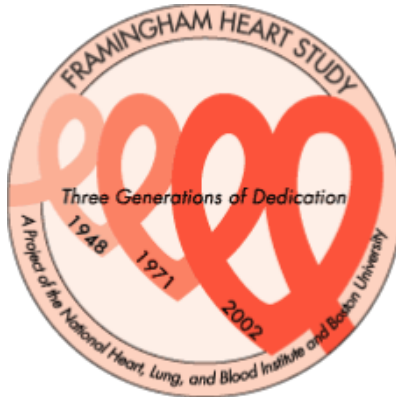
Other

	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

Additional Comments

Clinical Diagnostic Impression



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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.

branch_logic

[View equation](#)

Form is intentionally left blank

- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

Second examiner ID number

FOR ALL SECOND OPINIONS

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

Congestive Heart Failure

Congestive heart failure

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

Coronary Heart Disease

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

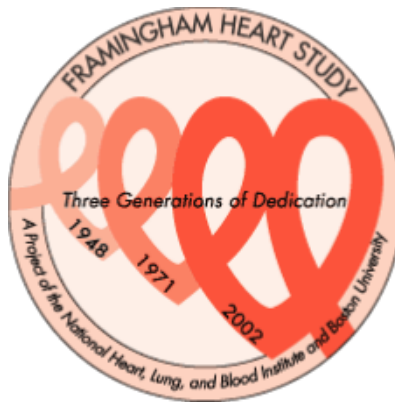
TIA

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

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

Additional Comments

Second Examiner Opinions



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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 130 or DBP \geq 80

ECG abnormality

☐ Yes

Specify abnormality

Clinic physician identified medical problem

☐ Yes

Specify medical problem

Other

☐ Yes

Specify other

Method Used to Inform Participant

Check ALL that apply

Yes

Face-to-face in clinic

☐

Phone call

☐

Result letter

☐

Other

☐

Method Used to Inform Participant's Personal Physician

Check ALL that apply

Yes

Phone call

☐

Result letter mailed

☐
Result letter FAX'd
- inform staff if FAX needed
☐

Other method - Physician

☐

Referral Date and Other Information

Date referral made



Today

M-D-Y

ID number of person completing referral

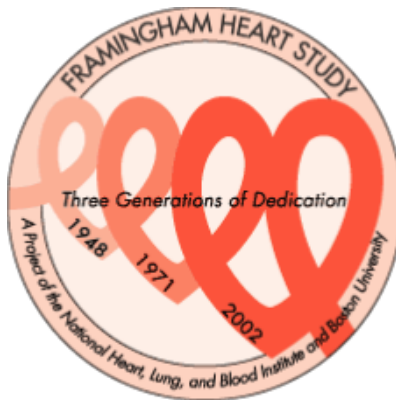
Notes documenting conversation with participant or participant's personal physician

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

- ☐ English
☐ Spanish
☐ Mixed
☐ Unknown

Additional Comments

Referral Tracking



Framingham Heart Study

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LETTER TO PHYSICIAN:

RESEARCH EXAMINATION REPORT OFFSPRING EXAM 10 / OMNI EXAM 5

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

Some research findings may be sent in a separate report.

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.

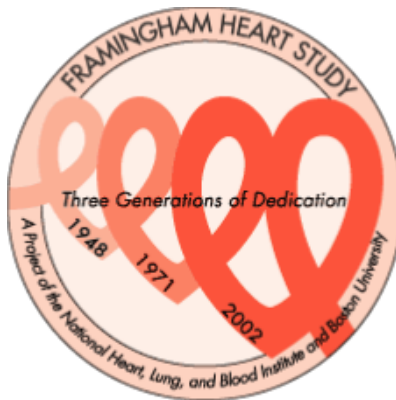
Thank you for your continuing support.

Examiner_____

Sincerely,

**Daniel Levy, MD
Director, Framingham Heart Study**

OMB No = 0925-0216 12/31/2016



Framingham Heart Study

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Medical Portion Date

Have you completed the Medical Portion?

- ☐ No
- ☐ Yes
- ☐ Partial
- ☐ Other

Medical portion completed on

* must provide value

 Today M-D-Y

Medical portion completed by

Comments for medical completion date

Framingham Heart Study

Offspring Exam 10

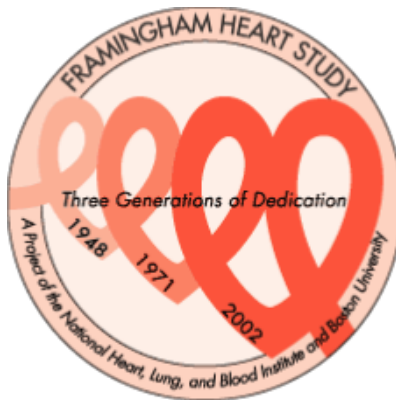
Omni 1 Exam 5

Research Center Questionnaire

SECTIONS:

Admit	(pages 1 – 4) plus consents
MD	(pages 5 – 118)
Self-Administered Questions	(pages 119 – 152)
Tech	(pages 153 – 224)
Tonometry	(pages 225 – 226)

Self-Administered Questions Section



Framingham Heart Study

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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 or 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.

Income includes, working for wages, social security benefits, pensions, retirement planning funds, and any other type of benefits.

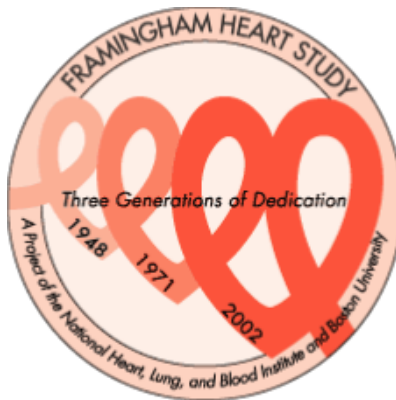
- ☐ Under \$20,000
- ☐ \$20,000 - \$34,999
- ☐ \$35,000 - \$54,999
- ☐ \$55,000 - \$74,999
- ☐ \$75,000 - \$100,000
- ☐ Over \$100,000
- ☐ Prefer not to answer

How many people are supported by this income?

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

Survey progress: 15% Complete

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Framingham Heart Study

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

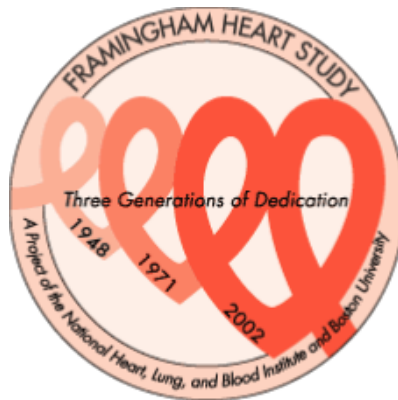
If "Yes"

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

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

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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

[reset](#)

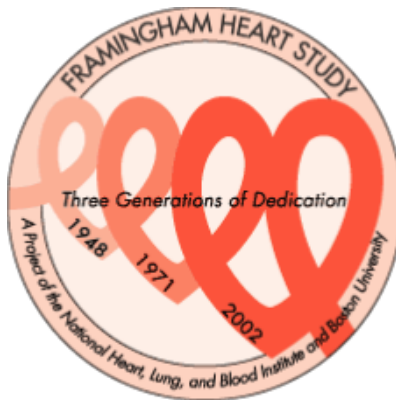
During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. Accomplished less than you would like

- ☐ Yes
☐ No

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

- ☐ Yes
☐ No



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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

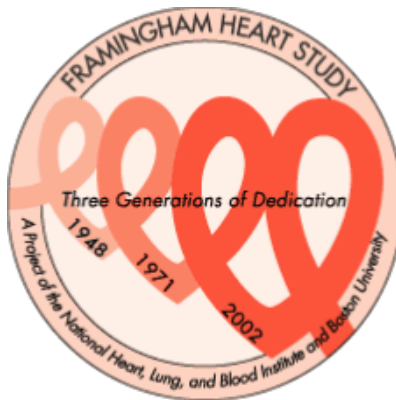
These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

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

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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"

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

Note: Being prescribed or taking an anti-coagulant medication such as coumadin/warfarin does not constitute a bleeding problem for you or your family member, unless a bleeding issue was experienced while on such medication.

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

- ☐ 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.

Expand

[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

[reset](#)

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

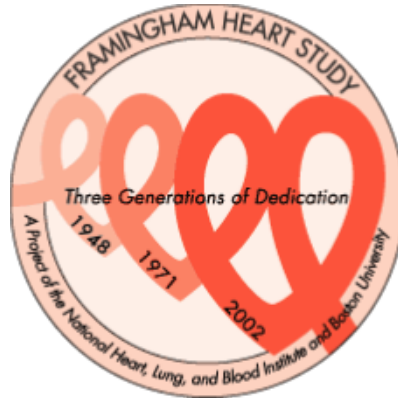
Name of treating doctor - delivery #5

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?



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Sleep Questionnaire

In the past 7 days...

My sleep quality was

- ☐ Very poor
- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very good

My sleep was refreshing

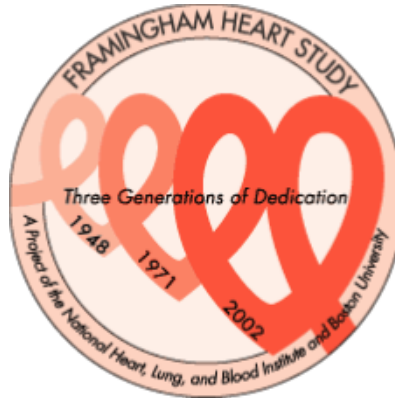
- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very Much

I had a problem with my sleep

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much

I had difficulty falling asleep

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very Much



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Cannabis Questionnaire

The following questions are about cannabis use. There are many other terms from cannabis and cannabis-containing products. These include marijuana, pot, weed and grass. Cannabis may be consumed in different forms, including smoked (cigarettes, joints, or pipe), vaped, edibles (mixed in food products or brewed), or by skin (creams or oils). Forms of cannabis contained in oil or creams may be called hash oil, THC oil, or butane hash oil.

Have you ever, even once, used cannabis?

- ☐ No
☐ Yes
☐ Prefer not to answer

If "Yes"

How old were you the first time you used cannabis?

Age in years,
999 = Unknown

Have you used cannabis in the past year?

- ☐ No
☐ Yes
☐ Prefer not to answer

If "Yes"

What are the reasons you used cannabis in the past year?

- ☐ Non-medical reasons only
(for example: for relaxation)
- ☐ Medical reasons only
(for example: for pain, cancer related symptoms, fibromyalgia, muscle spasms and tremors associated with multiple sclerosis, or Parkinson's Disease, etc)
- ☐ Both nonmedical and medical reasons
- ☐ Prefer not to answer

If "Medical reasons" or "Both medical and nonmedical reasons"

For what symptoms do you use cannabis?

	No	Yes	Prefer not to answer
Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If "Other"	<input type="text"/>		

For what medical conditions do you use cannabis?

	No	Yes	Prefer not to answer
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fibromyalgia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parkinson's Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If "Other"	<input type="text"/>		

How often did you use cannabis in the past year?

- ☐ Less than once per month
- ☐ Once or twice per month
- ☐ Once or twice per week
- ☐ Daily (or almost daily)
- ☐ More than once per day
- ☐ Prefer not to answer

When you used cannabis in the past year, what methods(s) did you use?

	No	Yes	Prefer not to answer
Smoke cannabis flower or bud (e.g. joint, pipe)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smoke cannabis concentrate (e.g., vape pen or e-device)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Edible form (including food, gels, gummies, teas, and other drinks)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Creams or oils/topical/skin/patch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If "Other"	<input type="text"/>		

What type of cannabis did you use?

	No	Yes	Not sure	Prefer not to answer
Equal parts THC/CBD (equal parts)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low THC/ high CBD (e.g. CBD oil or high CBD products)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High THC/ low CBD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Prior to last year, how often did you use cannabis?

- ☐ Did not use prior to this year
- ☐ Used once or a few times in my life
- ☐ Less than once per month
- ☐ Once or twice per month
- ☐ Once or twice per week
- ☐ Daily (or almost daily)
- ☐ More than once a day
- ☐ Prefer not to answer

If between "Less than once per month" and "More than once a day"

Prior to last year and since the time you started using cannabis at age [marijuanaage], did you ever stop using cannabis for more than a year?

- ☐ No
- ☐ Yes
- ☐ Prefer not to answer

If "Yes"

At what age did you stop using cannabis?

(If you have had more than one period of stopping and starting cannabis use, please list the most recent period.)

Age in years,
999 = Unknown

Did you start using cannabis again after this period of stopping?

- ☐ No
- ☐ Yes
- ☐ Prefer not to answer

If "Yes"

If you started using cannabis again after the period of stopping, at what age did you start using cannabis again?

(If you have had more than one period of stopping and starting cannabis use, please list the most recent period.)

Age in years,
999 = Unknown

Framingham Heart Study

Offspring Exam 10

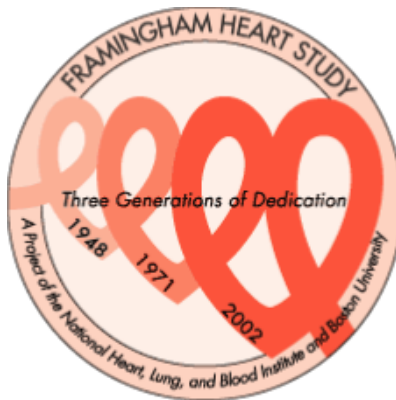
Omni 1 Exam 5

Research Center Questionnaire

SECTIONS:

Admit	(pages 1 – 4) plus consents
MD	(pages 5 – 118)
Self-Administered Questions	(pages 119 – 152)
Tech	(pages 153 – 224)
Tonometry	(pages 225 – 226)

Tech Section



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Basic Information and Anthropometrics

Form is intentionally left blank

- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other"

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**In the past year, have you lost more than 10 pounds?**

- ☐ No
☐ Yes, unintentionally, NOT due to dieting or exercise
☐ Yes, intentionally, due to dieting or exercise

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**

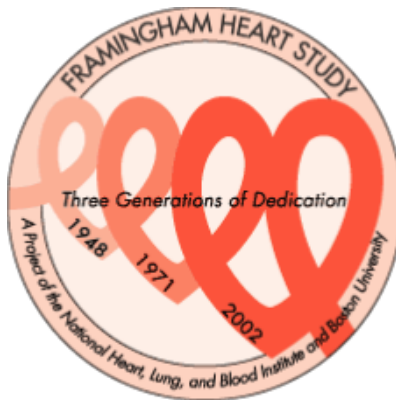
Inches, to next lower 1/4 inch,
88.88 = Refused,
99.99 = Not done or Unknown

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**



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CES-D

Handout

Form is intentionally left blank

- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other"

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)

I did not feel like eating; my appetite was poor.

- ☐ 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 I could not shake off the blues even with the help of my family or friends.

- ☐ 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 I was just as good as other people.

- ☐ 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 had trouble keeping my mind on what I was doing.

- ☐ 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)

During the past week, I felt depressed.

- ☐ 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 everything I did was an effort.

- ☐ 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 hopeful about the future.

- ☐ 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 thought my life had been a failure.

- ☐ 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 fearful.

- ☐ 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)

During the past week, my sleep was restless.

- ☐ 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 was happy.

- ☐ 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 talked less than usual.

- ☐ 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 lonely.

- ☐ 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)

People were unfriendly.

- ☐ 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 enjoyed life.

- ☐ 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 had crying spells.

- ☐ 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 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.

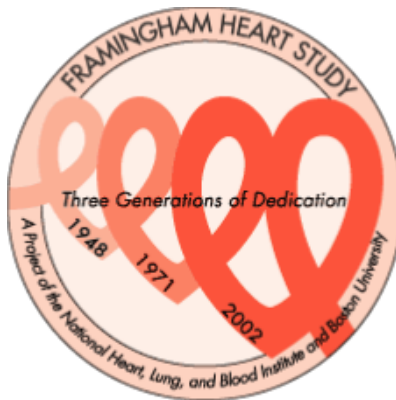
- ☐ Rarely or none of the time (less than 1 day)
- ☐ Some or a little of the time (1-2 days)
- ☐ Occasionally or a moderate amount of the time (3-4 days)
- ☐ Most or all of the time (5-7 days)

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 - Katz ADLS

Form is intentionally left blank

- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

Technician Number

Rosow Breslau Questions

	No	Yes	Unknown
Are you able to do heavy work around the house, like shoveling snow or washing windows, walls, or floors without help?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are you able to walk half a mile without help? (About 4-6 blocks)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If "No" or "Unknown"

Are you able to walk a quarter of a mile without help?
(About 2-3 blocks)

☐☐☐

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

☐☐☐

Katz ADLS

During the Course of a Normal Day, Can you do the following activities independently or do you need help from another person or use special equipment or a device?

Dressing (undressing and redressing)

Device such as: Velcro, elastic laces

- ☐ No help needed, independent
- ☐ Uses device, independent
- ☐ Human assistance needed, minimally dependent
- ☐ Dependent
- ☐ Do not do during a normal day
- ☐ Unknown

Bathing (including getting in and out of tub or shower)

Devices such as: bath chair, long handled sponge, hand held shower, safety bars

- ☐ No help needed, independent
- ☐ Uses device, independent
- ☐ Human assistance needed, minimally dependent
- ☐ Dependent
- ☐ Do not do during a normal day
- ☐ Unknown

Eating

Devices such as: rocking knife, spork, long straw, plate guard

- ☐ No help needed, independent
- ☐ Uses device, independent
- ☐ Human assistance needed, minimally dependent
- ☐ Dependent
- ☐ Do not do during a normal day
- ☐ Unknown

Transferring (getting in and out of a chair)

Devices such as: sliding board, grab bars, special seat

- ☐ No help needed, independent
- ☐ Uses device, independent
- ☐ Human assistance needed, minimally dependent
- ☐ Dependent
- ☐ Do not do during a normal day
- ☐ Unknown

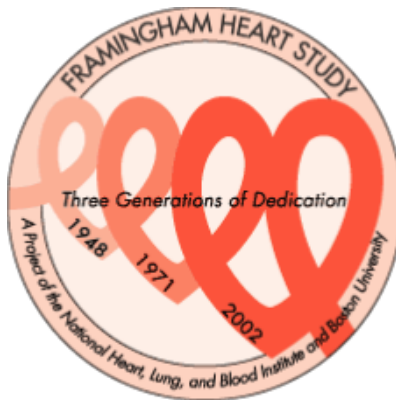
Toileting Activities (using bathroom facilities and handling clothing)

Devices such as: sliding board, grab bars, special seat

- ☐ No help needed, independent
- ☐ Uses device, independent
- ☐ Human assistance needed, minimally dependent
- ☐ Dependent
- ☐ Do not do during a normal day
- ☐ Unknown

Additional Comments

Rosow Breslau - Katz ADLS



Framingham Heart Study

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Nagi Questions

Handout

Form is intentionally left blank

- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

Technician Number

For each activity tell me whether you have:

Pulling or pushing large objects like a living room chair

- ☐ No difficulty
- ☐ A little difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Unable to do
- ☐ Don't do on MD orders
- ☐ Unknown

Either stooping, crouching, or kneeling

- ☐ No difficulty
- ☐ A little difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Unable to do
- ☐ Don't do on MD orders
- ☐ Unknown

Reaching or extending arms below shoulder level

- ☐ No difficulty
- ☐ A little difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Unable to do
- ☐ Don't do on MD orders
- ☐ Unknown

Reaching or extending arms above shoulder level

- ☐ No difficulty
- ☐ A little difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Unable to do
- ☐ Don't do on MD orders
- ☐ Unknown

Either writing, or handling, or fingering small objects

- ☐ No difficulty
- ☐ A little difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Unable to do
- ☐ Don't do on MD orders
- ☐ Unknown

Standing in one place for long periods, say 15 minutes

- ☐ No difficulty
- ☐ A little difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Unable to do
- ☐ Don't do on MD orders
- ☐ Unknown

Sitting for long periods, say 1 hour

- ☐ No difficulty
- ☐ A little difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Unable to do
- ☐ Don't do on MD orders
- ☐ Unknown

Lifting or carrying weights under 10 pound
(like a bag of potatoes)

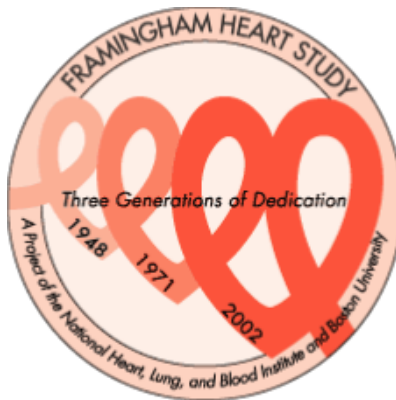
- ☐ No difficulty
- ☐ A little difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Unable to do
- ☐ Don't do on MD orders
- ☐ Unknown

Lifting or carrying weights over 10 pound
(like a very heavy bag of groceries)

- ☐ No difficulty
- ☐ A little difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Unable to do
- ☐ Don't do on MD orders
- ☐ Unknown

Additional Comments

Nagi Questions



Framingham Heart Study

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Socio-demographic Questionnaire

Form is intentionally left blank

- ☐ Refusal
- ☐ Short exam
- ☐ Split exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

Technician Number

Socio-demographics

Where do you live?

- ☐ Private residence (own/rent)
- ☐ Other setting, such as an assisted living facility
(i.e., no longer able to live independently)
- ☐ Nursing home
- ☐ Unknown

Does anyone live with you?

- ☐ No
- ☐ Yes
- ☐ Unknown

Code Nursing Home Residents as NO

If "Yes"

Spouse

- ☐ No
- ☐ Yes, more than 3 months per year
- ☐ Yes, less than 3 months per year
- ☐ Unknown

Significant Other/Partner

- ☐ No
- ☐ Yes, more than 3 months per year
- ☐ Yes, less than 3 months per year
- ☐ Unknown

Children

- ☐ No
- ☐ Yes, more than 3 months per year
- ☐ Yes, less than 3 months per year
- ☐ Unknown

Friend

- ☐ No
- ☐ Yes, more than 3 months per year
- ☐ Yes, less than 3 months per year
- ☐ Unknown

Relative

- ☐ No
- ☐ Yes, more than 3 months per year
- ☐ Yes, less than 3 months per year
- ☐ Unknown

Use of Nursing and Community Services

Have you been admitted to a nursing home (or skilled facility) in the past year?
(i.e. rehab facility)

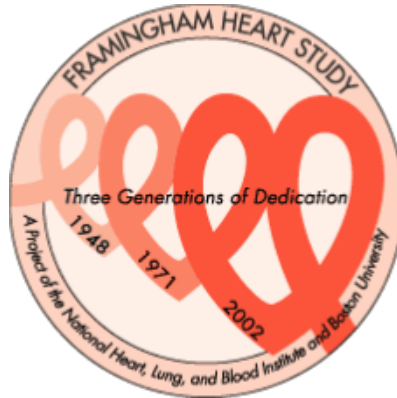
- ☐ No
- ☐ Yes
- ☐ Unknown

In the past year, have you been visited by a nursing service, or used home, community, or outpatient programs?

- ☐ No
- ☐ Yes
- ☐ Unknown

Additional Comments

Sociodemographic Questionnaire



Framingham Heart Study

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PASE - Activity Questionnaire

Form is intentionally left blank

- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

Technician Number

Leisure Time Activity Questionnaire

This questionnaire asks you questions about activities you may have done in the past seven days. Please answer each question with the response that best describes your activities in each section.

Over the past 7 days, how often did you participate in sitting activities such as reading, watching TV or doing handcrafts?

- ☐ Never
- ☐ Seldom, 1-2 days
- ☐ Sometimes, 3-4 days
- ☐ Often, 5-7 days
- ☐ Unknown

If "Seldom", "Sometimes", or "Often"

What were these activities?

On average, how many hours per day did you engage in these sitting activities?

- ☐ Less than 1 hour
- ☐ 1 hour but less than 2 hours
- ☐ 2-4 hours
- ☐ More than 4 hours
- ☐ Unknown

Over the past 7 days, how often did you take a walk outside your home or yard for any reason? For example, for fun or exercise, walking the dog or walking in a mall, etc.?

- ☐ Never
- ☐ Seldom, 1-2 days
- ☐ Sometimes, 3-4 days
- ☐ Often, 5-7 days
- ☐ Unknown

If "Seldom", "Sometimes", or "Often"

On average, how many hours per day did you spend walking?

- ☐ Less than 1 hour
- ☐ 1 hour but less than 2 hours
- ☐ 2-4 hours
- ☐ More than 4 hours
- ☐ Unknown

Over the past 7 days, how often did you engage in light sports or recreational activities such as bowling, golf with a cart, woodwork, fishing, ping-pong or other similar activities?

- ☐ Never
- ☐ Seldom, 1-2 days
- ☐ Sometimes, 3-4 days
- ☐ Often, 5-7 days
- ☐ Unknown

If "Seldom", "Sometimes", or "Often"

What were these activities?

On average, how many hours per day did you engage in these light sport or recreational activities?

- ☐ Less than 1 hour
- ☐ 1 hour but less than 2 hours
- ☐ 2-4 hours
- ☐ More than 4 hours
- ☐ Unknown

Over the past 7 days, how often did you engage in moderate sport and recreational activities such as doubles tennis, ballroom dancing, hunting, ice skating, golf without a cart, softball or other similar activities?

- ☐ Never
- ☐ Seldom, 1-2 days
- ☐ Sometimes, 3-4 days
- ☐ Often, 5-7 days
- ☐ Unknown

If "Seldom", "Sometimes", or "Often"

What were these activities?

On average, how many hours per day did you engage in these moderate sport or recreational activities?

- ☐ Less than 1 hour
- ☐ 1 hour but less than 2 hours
- ☐ 2-4 hours
- ☐ More than 4 hours
- ☐ Unknown

Over the past 7 days, how often did you engage in **strenuous** sport and recreational activities such as jogging, swimming, cycling, singles tennis, aerobic dance, skiing (downhill or cross-country) or other similar activities?

- ☐ Never
☐ Seldom, 1-2 days
☐ Sometimes, 3-4 days
☐ Often, 5-7 days
☐ Unknown

If "Seldom", "Sometimes", or "Often"

What were these activities?

On average, how many hours per day did you engage in these **strenuous** sport or recreational activities?

- ☐ Less than 1 hour
☐ 1 hour but less than 2 hours
☐ 2-4 hours
☐ More than 4 hours
☐ Unknown

Over the past 7 days, how often did you do any **exercise** specifically to increase muscle strength and endurance, such as lifting weights, isometrics or physical therapy with weights, etc?

- ☐ Never
☐ Seldom, 1-2 days
☐ Sometimes, 3-4 days
☐ Often, 5-7 days
☐ Unknown

If "Seldom", "Sometimes", or "Often"

What were these activities?

On average, how many hours per day did you engage in **exercise** to increase muscle strength and endurance?

- ☐ Less than 1 hour
☐ 1 hour but less than 2 hours
☐ 2-4 hours
☐ More than 4 hours
☐ Unknown

Household Activity

During the past 7 days, have you done any light housework, such as dusting, washing or drying dishes, or ironing?

- ☐ No
☐ Yes
☐ Unknown

During the past 7 days, have you done any heavy housework or chores, such as vacuuming, scrubbing floors, washing windows, or carrying wood?

- ☐ No
☐ Yes
☐ Unknown

During the past 7 days, did you engage in any of the following activities?

	No	Yes	Unknown
Home repairs like painting, wallpapering, electrical work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lawn work or yard care, including snow or leaf removal, wood chopping, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Outdoor gardening	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Caring for an other person, such as children, dependent spouse, or an other adult



Work Related Activity

During the past 7 days, did you work for pay or as a volunteer?

☐ No☐ Yes☐ Unknown

If "Yes"

How many hours per week did you work for pay and/or as a volunteer?

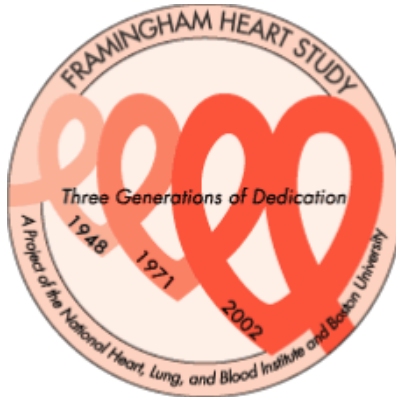
Number of hours, 99 = Unknown

Which one of the following categories best describes the amount of physical activity required on your job and/or volunteer work?

- ☐ Mainly sitting with slight arm movements.
(Examples: office worker, watchmaker, seated assembly line worker, bus driver, etc.)
- ☐ Sitting or standing with some walking.
(Examples: cashier, general office worker, light tool and machinery worker).
- ☐ Walking, with some handling of materials generally weighing less than 50 pounds.
(Examples: mailman, waiter/waitress, construction worker, heavy tool and machinery worker).
- ☐ Walking and heavy manual work often requiring handling of materials weighing over 50 pounds.
(Examples: lumberjack, stone mason, farm or general laborer).
- ☐ Unknown

Additional Comments

PASE - Activity Questionnaire



Framingham Heart Study

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Respiratory Disease

Age at last exam

[View equation](#)

Form is intentionally left blank

- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

Technician Number

Respiratory Diagnoses

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

- ☐ No
- ☐ Yes
- ☐ Unknown

Have you had asthma?

If "Yes"

Do you still have asthma?

- ☐ No
- ☐ Yes
- ☐ Unknown

Was the asthma diagnosed by a doctor or other health care professional?

- ☐ No
☐ Yes
☐ Unknown

If asthma started since your last exam, at what age did it start?

Age in years,
888 = If asthma started before last exam,
999 = Unknown

If you no longer have asthma, at what age did it stop?

Age in years,
888 = Still have it,
999 = Unknown

Have you received medical treatment for this in the past 12 months?

- ☐ No
☐ Yes
☐ Unknown

Have you EVER had any of the following conditions diagnosed by a doctor or other health care professional?

Chronic Bronchitis

- ☐ No
☐ Yes
☐ Unknown

Emphysema

- ☐ No
☐ Yes
☐ Unknown

COPD (Chronic Obstructive Pulmonary Disease)

- ☐ No
☐ Yes
☐ Unknown

Sleep Apnea

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

Do you wear a mask ("CPAP", "BIPAP") or other device at night to treat sleep apnea?

- ☐ No
☐ Yes
☐ Unknown

Pulmonary Fibrosis or Interstitial Lung Disease

- ☐ No
☐ Yes
☐ Unknown

Acute Respiratory Illness Since Last Exam

Since your last exam or medical history update ([lastmedinfodate]) ...?

Have you been hospitalized because of breathing trouble or wheezing?

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

How many times has this occurred?

99 = Unknown

Were any of these hospitalizations due to a lung or bronchial problem, for example, COPD, asthma, bronchitis, emphysema, or pneumonia?

- ☐ No
☐ Yes
☐ Unknown

Have you required an emergency room visit or an unscheduled visit to a doctor's office or clinic because of breathing trouble or wheezing?

- ☐ No
☐ Yes
☐ Unknown

If "Yes"

How many times has this occurred?

99 = Unknown

Were any of these emergency room or unscheduled visits due to a lung or bronchial problem, for example, COPD, asthma, bronchitis, emphysema, or pneumonia?

- ☐ No
☐ Yes
☐ Unknown

Have you had pneumonia (including bronchopneumonia)?

- ☐ No
☐ Yes
☐ Unknown

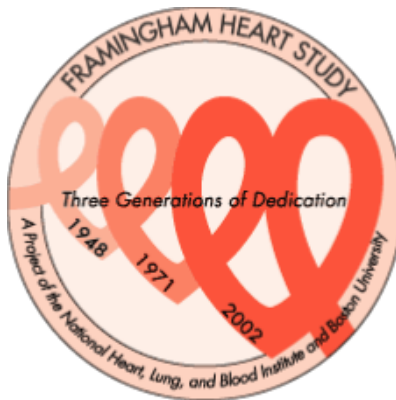
If "Yes"

How many times have you had pneumonia?

99 = Unknown

Additional Comments

Respiratory Disease



Framingham Heart Study

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

Fractures

Form is intentionally left blank

- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

Technician Number

Since your last exam or medical history update ([lastmedinfodate]) have you broken any bones?

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

Location of fracture

- ☐ Clavicle (collar bone)
- ☐ Upper arm (humerus) or elbow
- ☐ Forearm or wrist
- ☐ Hand
- ☐ Back (If disc disease only, code as no)
- ☐ Pelvis
- ☐ Hip
- ☐ Leg
- ☐ Foot
- ☐ Other

If "Other"

Location of fracture site for "Other"

Year

1971-2022,
9999 = Unknown

DATE details

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

Name of hospital

Location of hospital

Check here for additional comments

☐ Yes

Have you had a second fracture?

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

If "Yes" or "Maybe"

Location of fracture

- ☐ Clavicle (collar bone)
- ☐ Upper arm (humerus) or elbow
- ☐ Forearm or wrist
- ☐ Hand
- ☐ Back (If disc disease only, code as no)
- ☐ Pelvis
- ☐ Hip
- ☐ Leg
- ☐ Foot
- ☐ Other

If "Other"

Location of fracture site for "Other"

Year1971-2022,
9999 = Unknown**DATE details**

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

Name of hospital**Location of hospital****Check here for additional comments**☐ Yes**Have you had a third fracture?**

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

If "Yes" or "Maybe"**Location of fracture**

- ☐ Clavicle (collar bone)
☐ Upper arm (humerus) or elbow
☐ Forearm or wrist
☐ Hand
☐ Back (If disc disease only, code as no)
☐ Pelvis
☐ Hip
☐ Leg
☐ Foot
☐ Other

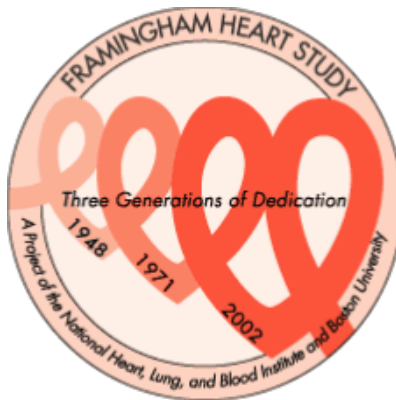
If "Other"**Location of fracture site for "Other"****Year**1971-2022,
9999 = Unknown**DATE details**

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

Name of hospital**Location of hospital****Check here for additional comments**☐ Yes

Additional Comments

Fractures



Framingham Heart Study

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MMSE Cognitive Function

Form is intentionally left blank

- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

Technician Number

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

What is the date today? (Month, Day, Year)

- ☐ MONTH - correct
- ☐ DAY - correct
- ☐ YEAR - correct
- ☐ Other
- ☐ Test item not administered or invalid

If "Other"

"Other"

If "Test item not administered or invalid"

Reason - "DATE" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

Other - reason?

Score - DATE

0 = Incorrect

1 = One correct

2 = Two correct

3 = Three correct

9 = Test item not administered or invalid

[View equation](#)

Month, day, year, correct score = 3

What is the season?

- ☐ WINTER - correct
- ☐ SPRING - correct
- ☐ SUMMER - correct
- ☐ FALL - correct
- ☐ Incorrect
- ☐ Test item not administered or invalid

If "Incorrect"

"Incorrect" response to What is the season?

If "Test item not administered or invalid"

Reason - "SEASON" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

"Other" reason?

Score - SEASON

0 = Incorrect

1 = Correct

9 = Test item not administered or invalid

[View equation](#)

What day of the week is it?

- ☐ SUNDAY - correct
- ☐ MONDAY - correct
- ☐ TUESDAY - correct
- ☐ WEDNESDAY - correct
- ☐ THURSDAY - correct
- ☐ FRIDAY - correct
- ☐ SATURDAY - correct
- ☐ Incorrect
- ☐ Test item not administered or invalid

If "Incorrect"

"Incorrect" response to What day of the week is it?

If "Test item not administered or invalid"

Reason - "DAY OF WEEK" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

"Other" reason?

Score - DAY OF THE WEEK

0 = Incorrect

1 = Correct

9 = Test item not administered or invalid

[View equation](#)

What Town, County and State are we in?

Framingham, Middlesex, MA

- ☐ TOWN - correct
- ☐ COUNTY - correct
- ☐ STATE - correct
- ☐ Other
- ☐ Test item not administered or invalid

If "Other"

"Other"

If "Test item not administered or invalid"

Reason - "TOWN, COUNTY, STATE" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

"Other" reason?

Score - TOWN, COUNTY and STATE

0 = Incorrect

1 = One correct

2 = Two correct

3 = Three correct

9 = Test item not administered or invalid

[View equation](#)

Town, county, state, correct score=3

What is the name of this place?

- ☐ FHS, Heart Center, Heart Study, Perini - correct
(Offsite only: my home, address) - correct
- ☐ Incorrect
- ☐ Test item not administered or invalid

If "Incorrect"

"Incorrect" response to What is the name of this place?

If "Test item not administered or invalid"

Reason - "PLACE" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

"Other" reason?

Score - PLACE

0 = Incorrect

1 = Correct

9 = Test item not administered or invalid

[View equation](#)

max score=1

What floor of the building are we on?

- ☐ Main floor, ground floor, 1st floor - correct
- ☐ Incorrect
- ☐ Test item not administered or invalid

If "Incorrect"

"Incorrect" response to What floor of the building are we on?

If "Test item not administered or invalid"

Reason - "FLOOR" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

"Other" reason?

Score - FLOOR

0 = Incorrect

1 = Correct

9 = Test item not administered or invalid

[View equation](#)

I am going to name 3 objects. After I have said them I want you to repeat them back to me. Are you ready? **Apple, Table, Penny**. Could you repeat the three items for me? Remember what they are because I will ask you to name them again in a few minutes.

- ☐ APPLE - correct
- ☐ TABLE - correct
- ☐ PENNY - correct
- ☐ Other
- ☐ Test item not administered or invalid

If "Other"

"Other"

If "Test item not administered or invalid"

Reason - "APPLE, TABLE, PENNY" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

"Other" reason?

Score - APPLE, TABLE, PENNY

0 = Incorrect

1 = One correct

2 = Two correct

3 = Three correct

9 = Test item not administered or invalid

[View equation](#)

**Now I am going to spell a word forward and I want you to spell it backwards. The word is world. W-O-R-L-D
Please spell it in reverse order**

66666=Not administered for reason unrelated to cognitive status,
00000=Administered, but couldn't do,
99999=Unknown

What are the 3 objects I asked you to remember?

- ☐ APPLE - correct
- ☐ TABLE - correct
- ☐ PENNY - correct
- ☐ Other
- ☐ Test item not administered or invalid

If "Other"

"Other"

If "Test item not administered or invalid"

Reason - "REPEAT - APPLE, TABLE, PENNY" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

"Other" reason?

Score - REPEAT - APPLE TABLE PENNY

0 = Incorrect

1 = One correct

2 = Two correct

3 = Three correct

9 = Test item not administered or invalid

[View equation](#)

What is this called?

(WATCH)

- ☐ WATCH - correct
- ☐ Incorrect
- ☐ Test item not administered or invalid

If "Incorrect"

"Incorrect" response to What is the called (watch)?

If "Test item not administered or invalid"

Reason - "WATCH" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

"Other" reason?

Score - WATCH

0 = Incorrect

1 = Correct

9 = Test item not administered or invalid

[View equation](#)

What is this called?
(PENCIL)

- ☐ PENCIL - correct
- ☐ Incorrect
- ☐ Test item not administered or invalid

If "Incorrect"

"Incorrect" response to What is this called
(pencil)?

If "Test item not administered or invalid"

Reason - "PENCIL" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

"Other" reason?

Score - PENCIL

0 = Incorrect

1 = Correct

9 = Test item not administered or invalid

[View equation](#)

Please repeat the following: "**NO IFS, ANDS, OR BUTS**".

- ☐ No Ifs, Ands or Buts - correct
- ☐ Incorrect
- ☐ Test item not administered or invalid

If "Incorrect"

"Incorrect" response to What is the name of this place?

If "Test item not administered or invalid"

Reason - "REPEAT" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

"Other" reason?

Score - REPEAT - "NO IFS, ANDS, OR BUTS"

0 = Incorrect

1 = Correct

9 = Test item not administered or invalid

[View equation](#)

Perfect = Correct

Please read the following and do what it says.
(Please close your eyes)

- ☐ Please close your eyes - correct
- ☐ Incorrect
- ☐ Test item not administered or invalid

If "Incorrect"

"Incorrect" response to What is the name of this place?

If "Test item not administered or invalid"

Reason - "READ AND FOLLOW THE DIRECTIONS" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

"Other" reason?

Score - READ AND FOLLOW DIRECTIONS

0 = Incorrect

1 = Correct

9 = Test item not administ

[View equation](#)

Performed = Correct

Please write a sentence.

- ☐ Sentence - correct
- ☐ Incorrect
- ☐ Test item not administered or invalid

If "Test item not administered or invalid"

Reason - "SENTENCE" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"**What is the environmental distraction?****If "Other"****"Other" reason?****Score - SENTENCE**

0 = Incorrect

1 = Correct

9 = Test item not administ

[View equation](#)**Please copy this drawing****If "Test item not administered or invalid"**

- ☐ Drawing - correct
- ☐ Incorrect
- ☐ Test item not administered or invalid

Reason - "DRAWING" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"**What is the physical limitation?****If "Environmental distraction"****What is the environmental distraction?****If "Other"****"Other" reason?****Score - DRAWING**

0 = Incorrect

1 = Correct

9 = Test item not administ

[View equation](#)**Take this piece of paper in your right hand, fold it in half with both hands, and put in your lap.**

- ☐ Take paper in right hand - correct
- ☐ Fold in half with both hands - correct
- ☐ Put in your lap - correct
- ☐ Other
- ☐ Test item not administered or invalid

[if not done correctly, write down what was done](#)**If "Other"****"Other"****If "Test item not administered or invalid"**

Reason - "FOLLOWED INSTRUCTIONS" score

- ☐ Poor hearing
- ☐ Poor vision
- ☐ Not fluent in English
- ☐ Illiteracy or low education
- ☐ Physical limitation
- ☐ Depression
- ☐ Anxiety
- ☐ Fatigue/frustration
- ☐ Refused
- ☐ Poor effort
- ☐ Difficulty understanding instructions
- ☐ Response unintelligible
- ☐ Environmental distraction
- ☐ Experimenter error
- ☐ Other

If "Physical limitation"

What is the physical limitation?

If "Environmental distraction"

What is the environmental distraction?

If "Other"

"Other" reason?

Score - FOLLOWED INSTRUCTIONS

0 = Incorrect

1 = One correct

2 = Two correct

3 = Three correct

9 = Test item not administered or invalid

[View equation](#)

Factor Potentially Affecting Mental Status Testing

Poor hearing

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

Poor vision

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

Not fluent in English

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

Illiteracy or low education

- ☐ No
- ☐ Yes
- ☐ Maybe
- ☐ Unknown

Psychological factors
(e.g., depression, anxiety, frustration)

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

Poor effort

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

Difficulty understanding instructions

- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

"Other" factor

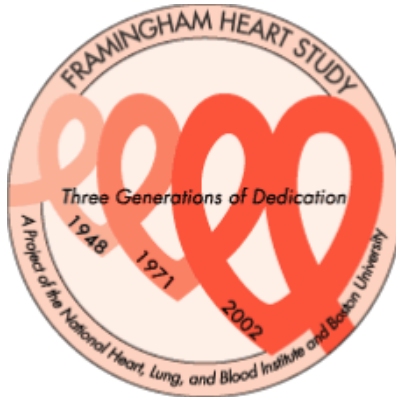
- ☐ No
☐ Yes
☐ Maybe
☐ Unknown

If "Yes" or "Maybe"

Other (describe)

Additional Comments

MMSE-Cognitive Function



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Hand Grip Test

Form is intentionally left blank

- ☐ Physical limitation
- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other" or "Physical limitation"

Reason why form was left blank

Technician Number

Right hand

Trial 1

Nearest kilogram,
99 = Unknown

Trial 2

Nearest kilogram,
99 = Unknown

Trial 3

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?**

☐ Test NOT completed

If checked

If "Test NOT completed" why not?

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

Other reason test not done

Write in reason

Protocol Modification - Hand Grip

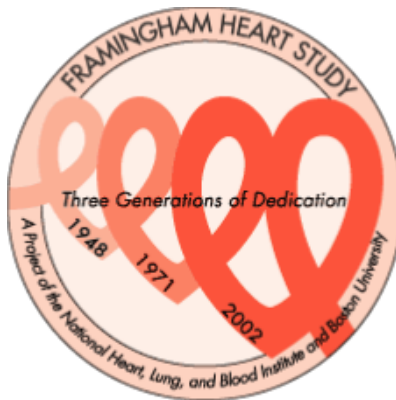
☐ Yes

If "Yes"

Comments protocol modification - Hand Grip

Additional Comments

Hand Grip Test



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Walk Test

Form is intentionally left blank

- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

Technician Number

Measured Walks

Walking aid used

- ☐ No aid
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Other
- ☐ Unknown

Course in meters (offsite only)

- ☐ 3m
- ☐ 4m

First Walk**Walk time stop watch**

Seconds,
99.99 = Unknown

Test not completed or not attempted☐ Yes**If "Yes"****If not attempted or completed, why not?**

- ☐ Physical limitation
☐ Refused
☐ Other
☐ Unknown

If "Other"**Other reason test not attempted or completed****Second Walk****Walk time stop watch**

Seconds,
99.99 = Unknown

Test not completed or not attempted☐ Yes**If "Yes"****If not attempted or completed, why not?**

- ☐ Physical limitation
☐ Refused
☐ Other
☐ Unknown

If "Other"**Other reason test not attempted or completed****Quick Walk****Walk time stop watch**

Seconds,
99.99 = Unknown

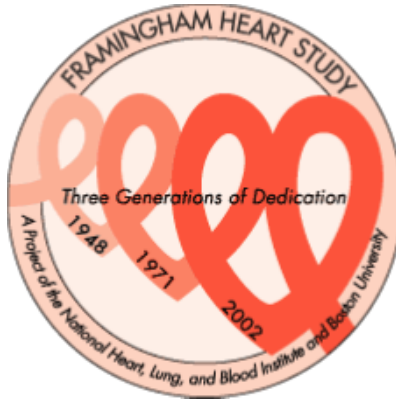
Test not completed or not attempted☐ Yes**If "Yes"****If not attempted or completed, why not?**

- ☐ Physical limitation
☐ Refused
☐ Other
☐ Unknown

If "Other"**Other reason test not attempted or completed**

Additional Comments

Observed Performance



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Tech Portion Date

Have you completed the Tech Portion?

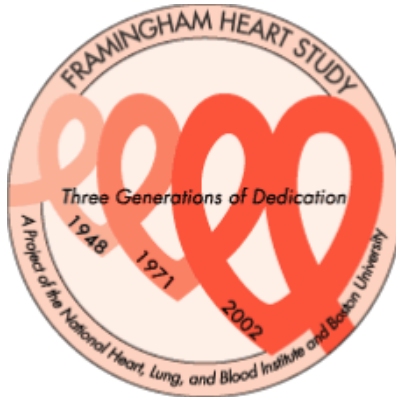
- ☐ No
- ☐ Yes
- ☐ Partial
- ☐ Other

Tech portion completed on

 Today M-D-Y

Tech portion completed by

Comments for technician completion date



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Community Assessment of Pain and Sensitization in the Elderly

General Pain question:

In this part of your study visit, we are interested in understanding what your experience of pain may be like. There are no right or wrong answers. We also understand that pain can change from day-to-day. Just answer to the best of your ability when thinking about any pain you may have had in the past week.

Form is intentionally left blank

- ☐ Proxy (answer questions 7, 8, and 10 only)
- ☐ Refusal
- ☐ Short exam
- ☐ Split exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

Technician Number

1. Thinking about any of the pain that you may have, please rate your pain by indicating the number that best describes your pain on AVERAGE in the PAST WEEK.

(rating scale in binder - #1)

- ☐ 0 = No Pain
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 = Pain as bad as you can imagine

2. In the PAST WEEK, have you had any CONSTANT pain?

- ☐ Yes
☐ No

3. In the PAST WEEK, how frequently have you had PAIN THAT COMES AND GOES?

(rating scale in binder - #3)

- ☐ Not at all/no pain
☐ Rarely
☐ Sometimes
☐ Often
☐ Very Often

4. Has your pain been present for MORE THAN 3 MONTHS, whether it is there constantly or comes and goes?

- ☐ Yes
☐ No

5. Have you had pain in the PAST WEEK?

- ☐ Yes, I have had pain in the past week
☐ No, I have not had pain the past week

If "Yes"

Please indicate the number that best describes how much your pain has INTERFERED in the PAST WEEK with your...

(rating scale in binder - #5)

	0 = Does Not Interfere	1	2	3	4	5	6	7	8	9	10 = Complete Interfere:
General Activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking ability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Normal Work (includes both work outside the house and housework)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Relations with other people

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Sleep

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Enjoyment of life

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

6. When someone has pain, one may have good days and bad days. Similarly, one's thoughts and feelings about pain may also change on a day-to-day basis. We are interested in understanding your experience over the PAST WEEK, bearing in mind that the PAST WEEK may be different from your 'usual experience'.

During the past week:

(rating scale in binder - #6)

	Not at all	To a slight degree	To a moderate degree	To a great degree	All of the time
A. I kept thinking about how much I hurt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. I felt my pain overwhelmed me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. I was afraid that my pain would be worse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Now we want to understand where you may have had pain or tenderness during the past week. We will first ask about your joints, and then about other body areas.

7. On MOST DAYS, do you have pain, aching or stiffness in any of your joints?

☐ Yes

☐ No

If "Yes"

Joints - Look at diagram 1

	Shoulder	Elbow	Wrist	Hip	Knee	Ankle
Right Side of Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Side of Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hand Joints: Palms Down - Look at diagram 2

LEFT HAND

	Thumb	Index Finger	Middle Finger	Ring Finger	Pinky
Top Finger Joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Middle finger joint (Bottom thumb joint)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knuckle (Base of hand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RIGHT HAND

	Thumb	Index Finger	Middle Finger	Ring Finger	Pinky
Top Finger Joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Middle finger joint (Bottom thumb joint)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knuckle (Base of hand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Joints at Base of Toes - Look at diagram 3

	Big Toe	2nd Toe	3rd Toe	4th Toe	5th Toe
Left Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. This question is being skipped since you did not indicate any joint or body regions with pain.

10. Please indicate which body site(s) is (are) the most SEVERE LOCATION OF YOUR RECENT PAIN.

- | | |
|---------------------|------------------------------|
| Shoulder | <input type="checkbox"/> Yes |
| Elbow | <input type="checkbox"/> Yes |
| Wrist | <input type="checkbox"/> Yes |
| Hand/fingers | <input type="checkbox"/> Yes |
| Arm | <input type="checkbox"/> Yes |
| Hip | <input type="checkbox"/> Yes |
| Knee | <input type="checkbox"/> Yes |
| Ankle | <input type="checkbox"/> Yes |
| Foot/toe | <input type="checkbox"/> Yes |
| Leg | <input type="checkbox"/> Yes |
| Neck | <input type="checkbox"/> Yes |
| Back | <input type="checkbox"/> Yes |
| Headache | <input type="checkbox"/> Yes |
| Eye | <input type="checkbox"/> Yes |
| Jaw | <input type="checkbox"/> Yes |
| Face | <input type="checkbox"/> Yes |
| Chest | <input type="checkbox"/> Yes |
| Abdomen | <input type="checkbox"/> Yes |
| Pelvis | <input type="checkbox"/> Yes |

Pain - Look at diagram 5

11. Thinking about the ways and areas in which you may experience pain, please look at diagram 5 and select which one best describes the course of your pain.

- ☐ Persistent pain with slight fluctuations
- ☐ Persistent pain with pain attacks
- ☐ Pain attacks without pain between them
- ☐ Pain attacks with pain between them
- ☐ No pain

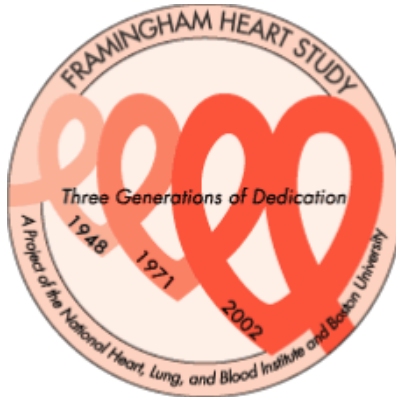
12. Does your pain radiate to other regions of your body?

- ☐ Yes
- ☐ No

13. Answer every question below by selecting the answers as indicated. If you are unsure about how to answer, please think about any pain you may have and give the best ONE answer you can.

(rating scale in binder - #13)

	Never	Hardly noticed	Slightly	Moderately	Strongly	Very strongly
Do you suffer from a burning sensation (e.g., stinging nettles) where you feel pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you have a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is light touching (clothing, a blanket) painful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you have sudden pain attacks in the area of your pain, like electric shocks?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is cold or heat (bath water) occasionally painful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you suffer from a sensation of numbness in the areas where you feel pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does slight pressure, e.g., with a finger, trigger pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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Pressure Pain Threshold (PPT) and Conditioned Pain Modulation (CPM)

Form is intentionally left blank

- ☐ Refusal
- ☐ Short exam
- ☐ Split exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

Technician Number

Screening

In this part of your study visit, we are going to assess how your body responds to pressure on your skin.

Before we get started, I need to ask you a few questions to determine which shoulder and arm we are going to assess today.

Pressure Pain Threshold (PPT) will be applied to the RIGHT trapezius, unless contraindicated:

1. Has there been any recent (< 6 weeks) trauma/injury to RIGHT trapezius (top of shoulder)?

- ☐ No
- ☐ Yes

Must answer #1

2. Has there been any recent (< 6 weeks) trauma/injury to LEFT trapezius (top of shoulder)?
- ☐ No
☐ Yes

Must answer #2

The Conditioned Pain Modulation (CPM) protocol requires application of a blood pressure cuff to the arm **OPPOSITE** to the side that will have PPT assessed.

***Blood pressure contraindications: Heart attack within past 6 months, documented history of Raynaud's syndrome or disease, severe peripheral vascular disease, lymphedema (for example, with mastectomy), Takayasu's arteritis, fistula in the arm, or any other blood pressure contraindications. Self-report of any of these contraindications is acceptable.**

3. Are there any contraindications* to applying a blood pressure cuff on the LEFT arm?
- ☐ No
☐ Yes

Must answer #3

4. Are there any contraindications* to applying a blood pressure cuff on the RIGHT arm?
- ☐ No
☐ Yes

Must answer #4

	trauma/injury to RIGHT trapezius	trauma/injury to LEFT trapezius
PPT	(answer to #1)	(answer to #2)
	contraindications to applying a blood pressure cuff on the LEFT arm	contraindications to applying a blood pressure cuff on the RIGHT arm
CPM	(answer to #3)	(answer to #4)

check to see if Right arm is for PPT

[View equation](#)

check to see if LEFT arm is for PPT

[View equation](#)

5. Can PPT (Trapezius) be performed?
- ☐ No
☐ Yes

If "No"

STOP: End of test

6. Which trapezius will be used for PPT?
- ☐ Right
☐ Left

7. Can CPM (BP) be performed?
- ☐ No
☐ Yes

If "No"

Only perform PPT (Trapezius)

8. Which arm will be used for BP cuff inflation for CPM (*must be opposite to trapezius being tested for PPT)
- ☐ Right arm
☐ Left arm

Data Collection

Now I'm going to explain what we are going to do in this part of the visit.

Everyone responds to discomfort in different ways. We are interested in how your body responds to pressure on your skin. There are no right or wrong answers. For this test, I'm going to place this device on the top of your shoulder. During this test, pressure will gradually be applied. We are interested in learning the amount of pressure at which you **FIRST** begin to experience **SLIGHT** pain. As soon as the pressure from the test **FIRST** produces **SLIGHT** pain, say 'pain.' We are not interested in how **long** you can tolerate the pain, but rather when the pressure **FIRST** becomes **SLIGHTLY** painful.

Please tell me your understanding of what will occur during the test and what we'd like you to do.

Ok, I'm going to start at your [ppt_use] shoulder area.

I'm starting the first test now. **1st**

PPT (Trapezius)

1st - Trapezius - Trial #1 (answer to #6)

kg
99 = Unknown or test not done

Was 1st Trapezius Trial #1 done?

- ☐ No
☐ Yes

"I'm starting the second test now."

1st - Trapezius - Trial #2 (answer to #6)

kg
99 = Unknown or test not done

Was 1st Trapezius Trial #2 done?

- ☐ No
☐ Yes

"I'm starting the third test now."

1st - Trapezius - Trial #3 (answer to #6)

kg
99 = Unknown or test not done

Was 1st Trapezius Trial #3 done?

- ☐ No
☐ Yes

CPM: 2nd PPT (Post-BP Cuff inflation PPT)

We are now going to repeat the measurement at the same spot on the top of your shoulder to see if your exam changes in response to inflating a blood pressure cuff on your arm and squeezing a soft ball with your hand. After I inflate the cuff, I will ask you to squeeze the ball 10 times at a rate of once per second. I will then ask you to rate any pain you may have in your forearm on a scale of 0-10. I may ask you to repeat squeezing the soft ball until your level is ready for us to repeat the exam.

	1st MD/Nurse Practitioner Reading	2nd MD/Nurse Practitioner Reading
Systolic (to nearest 2 mmHg)	first systolic reading	second systolic reading
Diastolic (to nearest 2 mmHg)	first diastolic reading	second diastolic reading

Systolic blood pressure (answer to #8)
(Refer to BP measurement)

nearest 2 mm Hg

Examiner note: Inflate BP cuff to ~10mm Hg above systolic level and record inflation time:

Number of hand squeezes (grips) done

Examiner note: If pain rating is less than 4 after 10 ball squeezes, ask participant to squeeze ball in increments of 10 more times, asking for a pain rating each time. If 2 minutes has passed with pain rating $\geq 4/10$, go to second set of PPT

Please rate any pain you may have in your forearm now on a 0-10 scale, 0 being no pain.

Final Pain Rating prior to performing 2nd PPT:

- ☐ 0 = No pain
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 = Pain as bad as you can imagine

Examiner note:

If cuff is inflated for 2 minutes without pain rating of 4 or more, perform the PPT assessment. Mark the final pain rating prior to the PPT assessment and record the inflation time.

Hand squeezes (grips) are discontinued whenever the participant reports pain of 4 or more. At that point, perform the PPT assessment. Mark the final pain rating prior to the PPT assessment and record the inflation time.

At any time, discontinue cuff inflation at participant's request if pain is unbearable. The PPT assessment can be performed with the cuff deflated if the participant does not object to completion of the exam. Mark the final pain rating prior to the PPT assessment, and record the inflation time.

Deflate cuff after 3rd trial PPT measurement is obtained.

2nd PPT (Trapezius)

"I'm starting the first test now."

2nd - Trapezius - Trial #1 (answer to #6)

kg
99 = Unknown or test not done

Was 2nd Trapezius Trial #1 done?

- ☐ No
- ☐ Yes

"I'm starting the second test now."

2nd - Trapezius - Trial #2 (answer to #6)

kg
99 = Unknown or test not done

Was 2nd Trapezius Trial #2 done?

- ☐ No
- ☐ Yes

"I'm starting the third test now."

2nd - Trapezius - Trial #3 (answer to #6)

kg
99 = Unknown or test not done

Was 2nd Trapezius Trial #3 done?

- ☐ No
☐ Yes

Was the cuff deflated prior to completion of the PPT assessment?

- ☐ No
☐ Yes

Record total inflation time

Inflation time - MINUTES

minutes

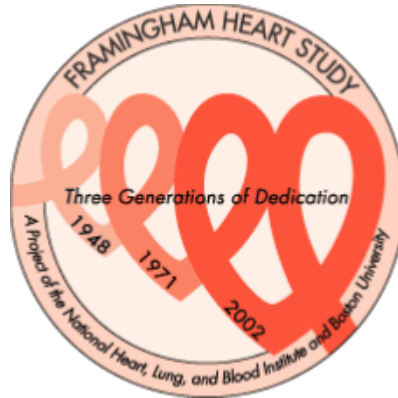
Inflation time - SECONDS

seconds

CPM (BP) cannot be performed on this participant.

Additional Comments

PPT (Trapezius) & CPM (BP)



Framingham Heart Study

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Exit Interview and Adverse Events

Form is intentionally left blank

- ☐ Refusal
- ☐ Short Exam
- ☐ Split Exam
- ☐ Offsite
- ☐ Other

If "Other"

Reason why form was left blank

Technician Number

Exit Interview

Was any of this exam done in Spanish?

☐ Yes

☐ No

Removed and placed bar code label in chart?

☐ Yes

☐ Bar code label not used

☐ Unknown

Referral sheet reviewed?

☐ No

☐ Yes

☐ Unknown

Proxy used to complete this exam

- ☐ No
- ☐ Yes, 1 proxy
- ☐ Yes, more than 1 proxy
- ☐ Unknown

If "Yes, 1 proxy"

If "Yes, more than 1 proxy"

Proxy name

Relationship

- ☐ 1st degree relative (spouse, child)
- ☐ Other relative
- ☐ Friend
- ☐ Health case professional
- ☐ Other
- ☐ Unknown

How long have you known the participant? - years

How long have you known the participant? - months

Are you currently living in the same household with the participant?

- ☐ No
- ☐ Yes
- ☐ Unknown

How often did you talk with the participant during the prior 11 months?

- ☐ Almost everyday
- ☐ Several times a week
- ☐ Once a week
- ☐ 1 to 3 times per month
- ☐ Less than once a month
- ☐ Unknown

If "Yes, more than 1 proxy"

Proxy 2 Name

Proxy 2 Relationship

- ☐ 1st degree relative (spouse, child)
- ☐ Other relative
- ☐ Friend
- ☐ Health case professional
- ☐ Other
- ☐ Unknown

Proxy 2 - How long have you known the participant? - years

Proxy 2 - How long have you known the participant? - months

Proxy 2 - Are you currently living in the same household with the participant?

- ☐ No
- ☐ Yes
- ☐ Unknown

Proxy 2 - How often did you talk with the participant during the prior 11 months?

- ☐ Almost everyday
- ☐ Several times a week
- ☐ Once a week
- ☐ 1 to 3 times per month
- ☐ Less than once a month
- ☐ Unknown

Dietary questionnaire brought to Research Center?

- ☐ No (refused)
- ☐ Yes
- ☐ Sent home
- ☐ Forgot to bring at time of exam, will mail
- ☐ Unknown

Left center with medications and belongings?

- ☐ No
- ☐ Yes
- ☐ Unknown

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 center 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

Offspring Exam 10

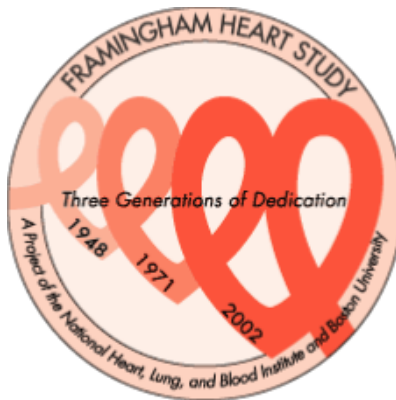
Omni 1 Exam 5

Research Center Questionnaire

SECTIONS:

Admit	(pages 1 – 4) plus consents
MD	(pages 5 – 118)
Self-Administered Questions	(pages 119 – 152)
Tech	(pages 153 – 224)
Tonometry	(pages 225 – 226)

Tonometry Section



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Tonometry Worksheet

Tonometry Worksheet Questions

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?**  Today 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**