Framingham Heart Study Medical History Update

For Office Use Only

TYPE ☐1) PHONE ☐2) MAILER ☐6) ONSITE ☐7) OFFSITE ☐10) EMAIL LINK ☐88) OTHER

INTERVIEWER |___|___|___|___| DATA ENTRY |___|___|___|___| 1 |___|___|___|___| 2

ID |___|___| - |___|___|___|___| DATE OF LAST EXAM OR UPDATE |___|___| - |___|___| - |___|___|___|___|

DATE COMPLETED (MM-DD-YYYY) |___|___| - |___|___| - |___|___|___|___|

FIRST NAME _____ LAST NAME _____

ADDRESS _____
Street City/Town State Zip code

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ EMAIL ADDRESS _____

1. Who is completing this form?

☐ Framingham Heart Study Participant whose name is above (**Go to page 2**)

☐ Someone other than participant (**Fill in below**)

Please answer the questions below <u>if someone other than the participant is providing information:</u>

Name of the person completing form: _____

Relationship to participant:
☐ Spouse/partner
☐ Family member other than spouse → Relationship: _____
☐ Friend
☐ Healthcare provider
☐ Other

Are you currently living in the same household as the participant? ☐ Yes ☐ No

How often have you talked with the participant during the past 12 months?

☐ Almost every day ☐ Several times a week ☐ Once a week
☐ 1 to 3 times per month ☐ Less than once a month ☐ Unknown or NA

Have you noticed that the participant has had memory problems during the past 12 months? ☐ Yes ☐ No

- If <u>YES</u>, has there been a diagnosis of dementia or Alzheimer's disease made by a doctor? ☐ Yes ☐ No

Is the participant able to sign a consent form? ☐ Yes ☐ No

- If <u>NO</u>, to whom should we send a consent form so that we can obtain medical records?
- Name: _____ Relationship: _____

Address: _____
Street City/Town State Zip code

Heart Problems

2. Have you received care at a physician's office, hospital, or urgent care facility for any problems with your heart since your last exam or update?

Chest pain, angina, or angina pectoris	☐ Yes	☐ No
Heart attack, myocardial infarction, or MI	☐ Yes	☐ No
Heart catheterization or cardiac catheterization	☐ Yes	☐ No
Procedure to unblock narrowed blood vessels to your heart muscles (PTCA, coronary angioplasty, or coronary stent)	☐ Yes	☐ No
Heart bypass operation, coronary bypass surgery or CABG	☐ Yes	☐ No
Heart failure or congestive heart failure or CHF	☐ Yes	☐ No
An irregular heartbeat called atrial fibrillation, atrial flutter or AF	☐ Yes	☐ No
A rhythm problem other than atrial fibrillation or atrial flutter	☐ Yes	☐ No

Specify other rhythm problem: _____

Insertion of a pacemaker or cardioverter- defibrillator (ICD or AICD)	☐ Yes	☐ No
A cardiac ablation or electrophysiology study (EP)	☐ Yes	☐ No
A valve repair or replacement	☐ Yes	☐ No
Any other heart problems that we have not discussed yet	☐ Yes	☐ No

Specify other heart problems: _____

Have you seen a cardiologist for any of the other problems	☐ Yes	☐ No

Comments – Heart Problems _____

If YES to any of the above, go to the next page.
If NO to all, go to "Circulatory Problems" on page 4.

FHS ID ____ - _____ DATE OF LAST EXAM OR UPDATE _____ - _____ - _____

Heart Related Medical Encounters

2a. Please fill out the following information for <u>each heart related encounter listed on the previous page</u>:

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

2b. Did you have any additional hospital, physician, or urgent care visits for <u>heart problems</u>?

☐ Yes (**Fill in below**) ☐ No (**Go to page 4**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

2c. Did you have any additional hospital, physician, or urgent care visits for <u>heart problems</u>?

☐ Yes (**Fill in below**) ☐ No (**Go to page 4**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

Comments – Heart Related Medical Encounters _____

Circulatory Problems

3. Have you received care at a physician's office, hospital, or urgent care facility for any circulatory problems since your last exam or update?

Procedure to unblock narrowed blood vessels in your neck (carotid endarterectomy, carotid angioplasty)	☐ Yes	☐ No
Poor blood circulation or blocked or narrowed blood vessels to the legs or feet, intermittent claudication, peripheral arterial disease, gangrene	☐ Yes	☐ No
Amputation of part of a leg or toes, because of poor circulation or gangrene	☐ Yes	☐ No
An aortic aneurysm or aortic dissection	☐ Yes	☐ No
Any other circulatory problems we have not discussed yet, not including varicose veins.	☐ Yes	☐ No

Specify other circulatory problems: _____

Blood clot or embolism in leg or lung	☐ Yes	☐ No

Comments – Circulatory Problems _____

If YES to any of the above, go to the next page.
If NO to all, go to "Neurological Problems" on page 6.

FHS ID ____ - _____ DATE OF LAST EXAM OR UPDATE _____ - _____ - _____

Circulatory Related Medical Encounters

3a. Please fill out the following information for each <u>circulatory encounter listed on the previous page</u>:

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

3b. Did you have any additional hospital, physician, or urgent care visits for <u>circulatory problems</u>? ☐ Yes (**Fill in below**) ☐ No (**Go to page 6**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

3c. Did you have any additional hospital, physician, or urgent care visits for <u>circulatory problems</u>? ☐ Yes (**Fill in below**) ☐ No (**Go to page 6**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

Comments – Circulatory Related Medical Encounters _____

Neurological Problems

4. Have you received care at a physician's office, hospital, or urgent care facility for any neurological problems since your last exam or update?

Stroke, TIA (transient ischemic attack), sudden paralysis, vision loss, inability to speak ☐ Yes ☐ No

Memory problems for which you saw a physician ☐ Yes ☐ No

Any other neurological problems **not limited to** Parkinson's, multiple sclerosis, seizures, head injury, loss of consciousness, dizziness ☐ Yes ☐ No

Specify other neurological problems: _____

Have you had an MRI scan of your head other than for the Framingham Heart Study? ☐ Yes ☐ No

Name of MRI Facility: _____

Year: _____

Date details (10/2, April, Summer, etc.) _____

Reason for MRI: _____

If response is yes to any of the questions above, did you see a neurologist? ☐ Yes ☐ No
(If yes, please enter neurology visit information on the next page.)

What is the name of neurologist you saw? _____

Comments – Neurological Problems _____

If YES to any of the above, go to the next page.
If NO to all, go to page 8.

FHS ID ____ - _____ DATE OF LAST EXAM OR UPDATE _____ - _____ - _____

Neurological Related Medical Encounters

4a. Please fill out the following information for each neurological encounter listed on the previous page:

Year |___|___|___|___| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

4b. Did you have any additional hospital, physician, or urgent care visits for neurological problems? ☐ Yes (**Fill in below**) ☐ No (**Go to page 8**)

Year |___|___|___|___| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

4c. Did you have any additional hospital, physician, or urgent care visits for neurological problems? ☐ Yes (**Fill in below**) ☐ No (**Go to page 8**)

Year |___|___|___|___| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

Comments – Neurological Related Medical Encounters _____

FHS ID ____ - _____ DATE OF LAST EXAM OR UPDATE _____ - _____ - _____

Cancer

5a. Have you received care at a physician's office, hospital, or urgent care facility <u>for cancer</u> since your last exam or update? ☐ Yes (**Fill in below**) ☐ No (**Go to page 11**)

I. What was the type of cancer? _____

II. Did you have a <u>biopsy</u>? ☐ Yes (**Fill in below**) ☐ No (**Go to next question**)

Was the biopsy done during a surgical procedure? ☐ Yes ☐ No

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

III. Did you have any other <u>surgery</u> for this cancer? ☐ Yes (**Fill in below**) ☐ No (**Go to next question**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

IV. Did you have <u>any other tests</u> to diagnose this cancer? ☐ Yes (**Fill in below**) ☐ No (**Go to next question**)

Type of test: _____

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

FHS ID ____ - _____ DATE OF LAST EXAM OR UPDATE _____ - _____ - _____

V. Did you see a physician/healthcare provider? ☐ Yes (**Fill in below**) ☐ No (**Go to page 11**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

5b. Have you received care at a physician's office, hospital, or urgent care facility for any other cancer since your last exam or update? ☐ Yes (**Fill in below**) ☐ No (**Go to page 11**)

I. What was the type of cancer? _____

II. Did you have a biopsy? ☐ Yes (**Fill in below**) ☐ No (**Go to next question**)

Was the biopsy done during a surgical procedure? ☐ Yes ☐ No

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

III. Did you have any other surgery for this cancer? ☐ Yes (**Fill in below**) ☐ No (**Go to next question**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

FHS ID ____ - _____ DATE OF LAST EXAM OR UPDATE _____ - _____ - _____

IV. Did you have <u>any other tests</u> to diagnose this cancer? ☐ Yes (**Fill in below**) ☐ No (**Go to next question**)

Type of test: _____

Year |___|___|___|___| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

V. Did you see a <u>physician/healthcare provider?</u> ☐ Yes (**Fill in below**) ☐ No (**Go to page 11**)

Year |___|___|___|___| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

FHS ID ____ - _____ DATE OF LAST EXAM OR UPDATE _____ - _____ - _____

Fractures

6a. Have you received care at a physician's office, hospital, or urgent care facility <u>for any fractures or broken bones</u> since your last exam or update? ☐ Yes (**Fill in below**) ☐ No (**Go to page 12**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Specify (including hip, back, arm, leg, pelvis, Collarbone, foot, toe, and others) _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

6b. Did you have <u>any other fractures or broken bones?</u> ☐ Yes (**Fill in below**) ☐ No (**Go to page 12**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Specify (including hip, back, arm, leg, pelvis, Collarbone, foot, toe, and others)
_____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ (city, state) Location of physician/healthcare provider: _____ (city, state)

6c. Did you have <u>any other fractures or broken bones?</u> ☐ Yes (**Fill in below**) ☐ No (**Go to page 12**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Specify (including hip, back, arm, leg, pelvis, Collarbone, foot, toe, and others)
_____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ Location of physician/healthcare provider: _____

FHS ID ____ - _____ DATE OF LAST EXAM OR UPDATE _____ - _____ - _____

(city, state) (city, state)

Other Problems (not including routine checkups

7a. Have you received care at a physician's office, hospital, or urgent care facility <u>for any other problems (not including routine checkups)</u> since your last exam or update? ☐ Yes (**Fill in below**) ☐ No (**Go to page 13**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ Location of physician/healthcare provider: _____
(city, state) (city, state)

7b. Did you have <u>any other problems?</u> ☐ Yes (**Fill in below**) ☐ No (**Go to page 13**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ Location of physician/healthcare provider: _____
(city, state) (city, state)

7c. Did you have <u>any other problems</u>? ☐ Yes (**Fill in below**) ☐ No (**Go to page 13**)

Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Type ☐ Overnight hospitalization ☐ Emergency Room Visit
☐ Day surgery/procedure ☐ Physician/Healthcare provider

Reason for visit: _____

Name of hospital/facility: _____ Name of physician/healthcare provider: _____

Location of hospital: _____ Location of physician/healthcare provider: _____
(city, state) (city, state)

Comments - Cancer/ Fractures/ Other Problems _____

FHS ID ____ - _____ DATE OF LAST EXAM OR UPDATE _____ - _____ - _____

Nursing Home/Rehabilitation/TCU Admissions

8a. Were you an overnight patient in a nursing home rehabilitation center or transitional care unit (TCU) since your last exam or update?

- ☐ Yes, discharged (**Fill in below**)
- ☐ Yes, currently residing in facility (**Fill in below**)
- ☐ No (**Go to "Diagnoses & Treatment Questions"**)

Name of nursing home/rehabilitation center/TCU: _____

Location of nursing home/rehabilitation center/TCU: _____
(city, state)

Date of admission: Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

8b. Were you an overnight patient in a nursing Home rehabilitation center or transitional care unit (TCU) at any other time since your last exam or update?

- ☐ Yes, discharged (**Fill in below**)
- ☐ Yes, currently residing in facility (**Fill in below**)
- ☐ No (**Go to "Diagnoses & Treatment Questions"**)

Name of nursing home/rehabilitation center/TCU: _____

Location of nursing home/rehabilitation center/TCU: _____
(city, state)

Date of admission: Year |____|____|____|____| Date details (10/2, April, Summer, etc.) _____

Diagnoses & Treatment Questions

High Blood Pressure or Hypertension

Have you been TOLD by your doctor you have high blood pressure or hypertension? ☐ Yes ☐ No ☐ Borderline ☐ Unknown

Are you CURRENTLY TAKING MEDICATION for high blood pressure or hypertension? ☐ Yes ☐ No ☐ Unknown

High Blood Cholesterol of High Triglycerides

Have you been TOLD by your doctor you have high blood cholesterol or high triglycerides? ☐ Yes ☐ No ☐ Borderline ☐ Unknown

Are you CURRENTLY TAKING MEDICATION for high blood cholesterol or high triglycerides? ☐ Yes ☐ No ☐ Unknown

High Blood Sugar or Diabetes

Have you been TOLD by your doctor you have high blood sugar or diabetes? ☐ Yes ☐ No ☐ Prediabetes/ Borderline ☐ Unknown

Are you CURRENTLY TAKING MEDICATION for high blood sugar or diabetes? ☐ Yes ☐ No ☐ Unknown

List all diabetes medications: _____

FHS ID ____ - _____ DATE OF LAST EXAM OR UPDATE _____ - _____ - _____

General Health

10. In general, how is your health now? (This question is to be answered only by the participant)

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't know

Definition: "without help" means without human assistance or a wheelchair

11. Are you able to walk 1/2 a mile without help? (about 4 to 6 blocks) ☐ Yes (**Go to "Pain Assessment"**) ☐ No ☐ Don't know

11a. Are you able to walk 1/4 mile without help? ☐ Yes ☐ No ☐ Don't know

Pain Assessment

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**.

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
No Pain										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**?

☐	☐	☐	☐	☐
0	1	2	3	4
Not at all/ no pain	Rarely	Sometimes	Often	Very Often

If you selected "0" for question 1 AND "No" to question 2 AND "0" to question 3 please skip question 4 and question 5a and 5b.

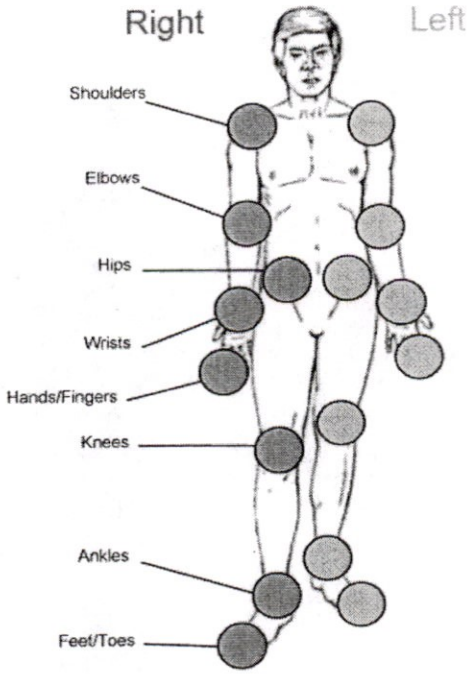
4. Has your pain been present for **MORE THAN 3 MONTHS**, whether it is there constantly or comes and goes?

☐ Yes ☐ No

5a. Looking at diagram below, do you have pain in any of your **JOINTS** that has lasted **AT LEAST 3 MONTHS**?

☐ Yes ☐ No (**Go to 5b**)

FHS ID ____ - _____ DATE OF LAST EXAM OR UPDATE _____ - _____ - _____

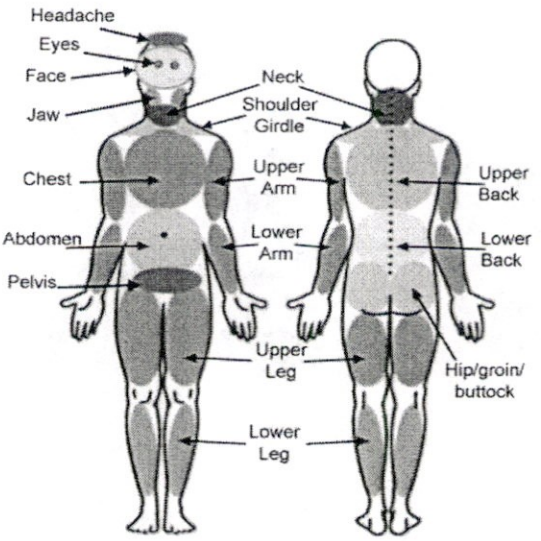


Mark **ALL JOINTS** in the body that have pain that has **LASTED AT LEAST 3 MONTHS**?

Joint Body Site			
Shoulder	☐ Right	☐ Left	☐ None
Elbow	☐ Right	☐ Left	☐ None
Hip	☐ Right	☐ Left	☐ None
Wrist	☐ Right	☐ Left	☐ None
Hand/fingers	☐ Right	☐ Left	☐ None
Knee	☐ Right	☐ Left	☐ None
Ankle	☐ Right	☐ Left	☐ None
Foot/toes	☐ Right	☐ Left	☐ None

5b. Looking at diagram below, do you have pain in any **BODY REGION OTHER THAN YOUR JOINTS** that has lasted **AT LEAST 3 MONTHS**?

☐ Yes ☐ No (**Go to page 17**)



Mark **ALL BODY REGIONS OTHER THAN THE JOINTS** that have pain that has **LASTED AT LEAST 3 MONTHS**?

Other Body Site

Front

Headache	☐ Yes	☐ No
Eyes	☐ Yes	☐ No
Face	☐ Yes	☐ No
Chest	☐ Yes	☐ No
Abdomen	☐ Yes	☐ No
Pelvis	☐ Yes	☐ No

Back

Neck	☐ Yes	☐ No
Upper Back	☐ Yes	☐ No
Lower Back	☐ Yes	☐ No

Other Body Sites

Jaw	☐ Right	☐ Left	☐ None
Shoulder Girdle	☐ Right	☐ Left	☐ None
Upper Arm	☐ Right	☐ Left	☐ None
Lower Arm	☐ Right	☐ Left	☐ None
Hip/Groin/Buttocks	☐ Right	☐ Left	☐ None
Upper Leg	☐ Right	☐ Left	☐ None
Lower Leg	☐ Right	☐ Left	☐ None

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Contact Person

12. Please list a person who does not live with you, but could provide contact information if we were unable to reach you:

Name: _____

What is your relationship to this person? _____

Address: Street 1 _____

Street 2 _____

City _____ State _____ Zip Code _____

Phone number _____

Email address _____

Comments – Contact Person _____

Primary Care Physician Information

13. What is the name of your primary care physician? _____

Address: Street 1 _____

Street 2 _____

City _____

State _____ Zip Code _____

Comments - Primary Care Physician _____

14. What is the name of the hospital you would typically go to if you needed emergency care?

Name of Hospital: _____ **City/State:** _____

YOU MIGHT BE SENT A CONSENT FORM TO SIGN SO THAT WE MAY OBTAIN YOUR MEDICAL RECORDS