### Numerical Data--Part I

OMB NO=0925-0216   12/31/2007

<table>
<thead>
<tr>
<th>Basic Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examiner's Number for Basic Information.</td>
</tr>
<tr>
<td>Sex of Participant (1=Male, 2=Female)</td>
</tr>
<tr>
<td>Age of Participant (years), 99=Unknown.</td>
</tr>
<tr>
<td>Site of Exam (0=Heart Study, 1=Nursing home, 2=Residence, 3=Other)</td>
</tr>
<tr>
<td>Weight (to nearest pound) Protocol modification 0=No 1=Yes</td>
</tr>
<tr>
<td>If offsite, fill ☐</td>
</tr>
<tr>
<td>Date weight obtained (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Height (inches, to next lower 1/4 inch) Protocol modification 0=No 1=Yes</td>
</tr>
<tr>
<td>In the past year, have you lost more than 10 pounds? 0=No, 1=Yes, unintentionally, NOT due to dieting or exercise, 2=Yes, intentionally, due to dieting or exercise</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Anthropometry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examiner's Number for anthropometry.</td>
</tr>
<tr>
<td>Waist Girth at umbilicus (inches, to next lower 1/4 inch) Protocol modification</td>
</tr>
<tr>
<td>Waist Girth at iliac crest (inches, to next lower 1/4 inch) Protocol modification</td>
</tr>
<tr>
<td>Sagittal abdominal diameter (to nearest 0.1 cm) Protocol modification</td>
</tr>
<tr>
<td>Are you fasting ≥ 8 hours?</td>
</tr>
</tbody>
</table>

Comments on all protocol modifications:

____________________________________________________

____________________________________________________

____________________________________________________

TECH01
## Exam 8 Procedures Sheet

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed Consent Signed</td>
<td>0=No, 1=Yes, 2=Consent signed, may qualify for waiver, 3=Waiver used, 4=Other</td>
</tr>
<tr>
<td>Anthropometry</td>
<td></td>
</tr>
<tr>
<td>Sociodemographic Questions</td>
<td></td>
</tr>
<tr>
<td>SF-12 Health Survey</td>
<td></td>
</tr>
<tr>
<td>CES-D Scale</td>
<td></td>
</tr>
<tr>
<td>Exercise Questionnaire</td>
<td></td>
</tr>
<tr>
<td>Mini-Mental Status Exam</td>
<td>0=No,</td>
</tr>
<tr>
<td>Urine Specimen</td>
<td>1=Yes,</td>
</tr>
<tr>
<td>Blood Draw</td>
<td></td>
</tr>
<tr>
<td>ECG</td>
<td></td>
</tr>
<tr>
<td>Observed performance (Timed walk hand grip)</td>
<td></td>
</tr>
<tr>
<td>Tonometry /ECHO/Carotid</td>
<td></td>
</tr>
<tr>
<td>Ankle-brachial blood pressure by Doppler.</td>
<td>8=Offsite visit</td>
</tr>
<tr>
<td>Spirometry</td>
<td></td>
</tr>
<tr>
<td>Post bronchodilator Spirometry</td>
<td></td>
</tr>
<tr>
<td>Diffusion Capacity</td>
<td></td>
</tr>
<tr>
<td>Reason Spirometry not done</td>
<td>1=Major Surgery, 2=Heart Attack 3=Stroke, 4=Aneurysm, 5=BP&gt;210/110 6=Refused, 7=Test Aborted, 8=Other, 10=equipment problems</td>
</tr>
<tr>
<td>Reason post bronchodilator test not done</td>
<td></td>
</tr>
<tr>
<td>Reason Diffusion not done</td>
<td></td>
</tr>
</tbody>
</table>

## Exit Interview

<table>
<thead>
<tr>
<th>Examiner ID</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure sheet reviewed</td>
<td>0=No</td>
</tr>
<tr>
<td>Referral sheet reviewed</td>
<td>1=Yes</td>
</tr>
<tr>
<td>Willett dietary questionnaire provided (if not completed in clinic)</td>
<td>8=Offsite</td>
</tr>
<tr>
<td>Left clinic w/ belongings</td>
<td></td>
</tr>
<tr>
<td>Feedback</td>
<td>0=No feedback, 1=Positive feedback, 2=Negative feedback, 3=Other</td>
</tr>
</tbody>
</table>

Comments ________________________________________________________________

______________________________________________________________

______________________________________________________________

TECH02
For Participants Wish to Complete Their Exam on a Second Visit

OMB NO=0925-0216  12/31/2007

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Exam Date</td>
<td>(If participant returns to finish their clinic exam on a date other than the original exam date, then fill in the date they return here. Otherwise leave entire page completely blank)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Fill in with 1=yes if procedure was done on the Second Exam Date and 0=no if procedure was not done on the Second Exam Date. Note that informed consent from first visit will cover the second visit.

| Exam 8 Procedures Sheet |
|---|---|
| □ | MD Questionaire. |
| □ | Anthropometry |
| □ | Sociodemographic Questions |
| □ | SF-12 Health Survey |
| □ | CES-D Scale |
| □ | Exercise Questionnaire |
| □ | Mini-Mental Status Exam |
| □ | Urine Specimen |
| □ | Blood Draw |
| □ | ECG |
| □ | Observed performance (Timed walk hand grip) |
| □ | Tonometry /ECHO/Carotid |
| □ | Ankle-brachial blood pressure by Doppler. |
| □ | Spirometry |
| □ | Post bronchodilator Spirometry |
| □ | Diffusion Capacity |

1=Major Surgery, 2=Heart Attack
3=Stroke, 4=Aneurysm, 5=BP>210/110
6=Refused, 7=Test Aborted, 8=Other, 10=equipment problems

TECH02a
### Rosow-Breslau Scale

**Socio-demographics**

<table>
<thead>
<tr>
<th>Examiner's Number</th>
<th>Examiner's Number for Socio-demographics</th>
</tr>
</thead>
</table>

**Where do you live?** (0=Private residence, 1=Nursing home, 2=Other institution, such as: assisted living, retirement community, 9=Unknown)

**Does anyone live with you?** (0=No, 1=Yes, 9=Unknown)

Code Nursing Home Residents as NO to these questions:

- **Spouse**
- **Significant Other**
- **Children**
- **Friends**
- **Relatives**

**Use of Nursing and Community Services**

- **Have you been admitted to a nursing home (or skilled facility) in the past year?**
- **In the past year, have you been visited by a nursing service, or used home, community, or outpatient programs?**

**Rosow-Breslau Questions**

- **Are you able to do heavy work around the house, like shoveling snow or washing windows, walls, or floors without help?**
- **Are you able to walk half a mile without help?** (About 4-6 blocks)
- **Are you able to walk up and down one flight of stairs without help?**

**CES-D Scale (Self-administered)**

**The questions below ask about your feelings.**

<table>
<thead>
<tr>
<th>Circle best answer for each question</th>
<th>Rarely or none of the time (less than 1 day)</th>
<th>Some or a little of the time (1-2 days)</th>
<th>Occasionally or moderate amount of time (3-4 days)</th>
<th>Most or all of the time (5-7 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DURING THE PAST WEEK</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. I felt that everything I did was an effort.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. I could not “get going”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

TECH03
Katz Activities of Daily Living Scale

OMB NO=0925-0216    12/31/2007

<table>
<thead>
<tr>
<th>Examiner's Number for Activities of Daily Living</th>
</tr>
</thead>
</table>

During the Course of a Normal Day, Can you do the following activities independently or do you need human assistance or the use of a device? Coding: 0=No help needed, independent,  1=Uses device, independent,  2=Human assistance needed, minimally dependent,  3=Dependent,  4=Do not do during a normal day,  9=Unknown

<table>
<thead>
<tr>
<th></th>
<th>Dressing (undressing and redressing)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Devices such as: velcro, elastic laces;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Bathing (including getting in and out of tub or shower)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Devices such as: bath chair, long handled sponge, hand held shower, safety bars;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Eating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Devices such as: rocking knife, spork, long straw, plate guard.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Transferring (getting in and out of a chair)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Devices such as: sliding board, grab bars, special seat;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Toileting Activities (using bathroom facilities and handle clothing)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Devices such as: special toilet seat, commode;</td>
</tr>
</tbody>
</table>

TECH04
### Physical Activity Questionnaire--Framingham Heart Study
#### Tech-administered

<table>
<thead>
<tr>
<th>Examine ID</th>
<th>Rest and Activity for a Typical Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Activities must equal 24 hours)</td>
</tr>
<tr>
<td></td>
<td>Number of hours</td>
</tr>
<tr>
<td><strong>Sleep</strong></td>
<td>Number of hours that you typically sleep?</td>
</tr>
<tr>
<td></td>
<td>_____</td>
</tr>
<tr>
<td><strong>Sedentary</strong></td>
<td>Number of hours typically sitting?</td>
</tr>
<tr>
<td></td>
<td>_____</td>
</tr>
<tr>
<td><strong>Slight Activity</strong></td>
<td>Number of hours with activities such as standing, walking?</td>
</tr>
<tr>
<td></td>
<td>_____</td>
</tr>
<tr>
<td><strong>Moderate Activity</strong></td>
<td>Number of hours with activities such as housework (vacuum, dust, yard chores, climbing stairs; light sports such as bowling, golf)?</td>
</tr>
<tr>
<td></td>
<td>_____</td>
</tr>
<tr>
<td><strong>Heavy Activity</strong></td>
<td>Number of hours with activities such as heavy household work, heavy yard work such as stacking or chopping wood, exercise such as intensive sports--jogging, swimming etc.?</td>
</tr>
<tr>
<td></td>
<td>_____</td>
</tr>
</tbody>
</table>

**Total number of hours**
(should be the total of above items)

24

What is your normal walking pace outdoors?

| 0 = Unable to walk |
| 1 = Easy, casual, slow (less than 2 miles per hour) |
| 2 = Normal, average (2 to 2.9 miles per hour) |
| 3 = Brisk pace (3 to 3.9 miles per hour) |
| 4 = Very brisk pace (4 to 4.9 miles per hour) |
| 9 = Unknown |

How many flights of stairs (not steps) do you climb daily? (10 stairs per flight)

| 0 = No flights |
| 1 = 1-2 flights |
| 2 = 3-4 flights |
| 3 = 5-9 flights |
| 4 = 10-14 flights |
| 5 = >15 flights |
| 9 = Unknown |

TECH05
I am going to read a list of activities. Please tell me which activities you have done in the past year.

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

TECH06
<table>
<thead>
<tr>
<th></th>
<th>Examiner's Number for Activities - Part B</th>
</tr>
</thead>
</table>

**Nagi Questions**

For each thing tell me whether you have

(0) No Difficulty  
(1) A Little Difficulty  
(2) Some Difficulty  
(3) A Lot Of Difficulty  
(4) Unable To Do  
(5) Don't Do On MD Orders  
(6) Unable to Assess Difficulty Because not Done as Part of Daily Activities  
(9) Unknown

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

TECH07
### Falls/Fractures

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<table>
<thead>
<tr>
<th>Examiner's Number for Activities - Part C</th>
</tr>
</thead>
</table>

**Fractures**

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

If Yes, fill

<table>
<thead>
<tr>
<th>Location of fracture:</th>
</tr>
</thead>
</table>

Location (code unknown as 99)

1. Clavicle (collar bone)
2. Upper arm (humerus) or elbow
3. Forearm or wrist
4. Hand
5. Back (If disc disease only, code as no)
6. Pelvis
7. Hip
8. Leg
9. Foot
10. Other (specify) ____________________________

TECH08
Cognitive Function--Part I

|__|__|__|
|__|__|__|

Examiner's Number

SCORE CORRECT
No Try=6 Unknown=9

Write all responses on exam form (score 1 point for each correct response)

What Is the Date Today?
0  1          6    9

What Is the Season?
0  1          6    9

What Day of the Week Is it?
0  1  2  3   6    9

What Town, County and State Are We in?
0  1           6    9

What Is the Name of this Place? (any appropriate answer all right, for instance my home, street address, heart study..max score=1)
0  1            6    9

What Floor of the Building Are We on?
0  1  2  3    6    9

I am going to name 3 objects. After I have said them I want you to repeat them back to me. Remember what they are because I will ask you to name them again in a few minutes:

Apple, Table, Penny

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. Write in Letters, ____________________ (Letters Are Entered and Scored Later)

Score as:

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 a few moments ago?

TECH09
### Cognitive Tests

#### What is this called?
- **Pen**
- **Watch**

#### Please repeat the following:

- "No ifs, ands, or buts."  
- *Perfect = 1*

#### Please read the following and do what it says

- (performed = 1, code 6 if low vision)

#### Please write a sentence

- (code 6 if low vision)

#### Please copy this drawing

- (code 6 if low vision)

---

**Take this piece of paper in your right hand, fold it in half with both hands, and put in your lap**

- (score 1 for each correctly performed act, code 6 if low vision)

<table>
<thead>
<tr>
<th>Factor Potentially Affecting Mental Status Testing</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate or low education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not fluent in English</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor eyesight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor hearing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression / possible depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, write in</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**TECH10**
### Observed performance. Part 1

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<table>
<thead>
<tr>
<th>Examiner's Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>HAND GRIP TEST</strong> Measured to the nearest kilogram</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Right hand</strong></td>
</tr>
<tr>
<td><strong>Trial 1</strong> 99=Unknown</td>
</tr>
<tr>
<td><strong>Trial 2</strong> 99=Unknown</td>
</tr>
<tr>
<td><strong>Trial 3</strong> 99=Unknown</td>
</tr>
</tbody>
</table>

| **Left hand**                                       |
| **Trial 1** 99=Unknown                              |
| **Trial 2** 99=Unknown                              |
| **Trial 3** 99=Unknown                              |

**Was this test completed?** (0=No, 1=Yes, 8=Not attempted, 9=Unknown)

If not attempted or completed, why not?
1=Physical limitation  2=Refused  3=Other write in  9=Unknown

TECH11
## MEASURED WALKS

**Walking aid used:** 0=No aid, 1=Cane, 2=Walker, 3=Wheelchair, 4=Other, 9=Unknown

### First Walk

- **Was this test completed?** (0=No, 1=Yes, 8=Not attempted, 9=Unknown)
- **If not attempted or completed, why not?**
  - 1=Physical limitation
  - 2=Refused
  - 3=Other ____________________ write in
  - 9=Unknown

- **Walk time** (in seconds, 99.99=Unknown)

### Second Walk

- **Was this test completed?** (0=No, 1=Yes, 8=Not attempted, 9=Unknown)
- **If not attempted or completed, why not?**
  - 1=Physical limitation
  - 2=Refused
  - 3=Other ____________________ write in
  - 9=Unknown

- **Walk time** (in seconds, 99.99=Unknown)

### Quick Walk

- **Was this test completed?** (0=No, 1=Yes, 8=Not attempted, 9=Unknown)
- **If not attempted or completed, why not?**
  - 1=Physical limitation
  - 2=Refused
  - 3=Other ____________________ write in
  - 9=Unknown

- **Walk time** (in seconds, 99.99=Unknown)
Doppler Ankle Brachial Blood Pressure Measurements.
Tech- Obtained

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SYSTOLIC BLOOD PRESSURES BY DOPPLER (to be taken in the following order with participant supine
after 5 minutes of rest)

<table>
<thead>
<tr>
<th>Examiner's Number for Doppler Ankle Brachial Blood Pressure.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuff size, arm</td>
</tr>
<tr>
<td>Cuff size, ankle</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Right arm</th>
<th>300=&gt;300</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right ankle</td>
<td>999= Unknown or not done</td>
</tr>
<tr>
<td>Left ankle</td>
<td></td>
</tr>
<tr>
<td>Left arm</td>
<td></td>
</tr>
</tbody>
</table>

REPEAT SYSTOLIC BLOOD PRESSURE MEASUREMENTS (reverse order)

<table>
<thead>
<tr>
<th>Left arm</th>
<th>300=&gt;300</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left ankle</td>
<td>999= Unknown or not done</td>
</tr>
<tr>
<td>Right ankle</td>
<td></td>
</tr>
<tr>
<td>Right arm</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Left arm</th>
<th>300=&gt;300</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left ankle</td>
<td>999= Unknown or not done</td>
</tr>
<tr>
<td>Right ankle</td>
<td></td>
</tr>
<tr>
<td>Right arm</td>
<td></td>
</tr>
</tbody>
</table>

Right Ankle blood pressure site
0= posterior tibial (ankle)
1= dorsalis pedis (foot)

Left Ankle blood pressure site

EXCLUSIONS:

<table>
<thead>
<tr>
<th>Right</th>
<th>Left</th>
<th>Lower Extremity Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0=None, 1=venous stasis ulceration,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2=amputation, 3=other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Right</th>
<th>Left</th>
<th>Upper Extremity Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0=None, 1=Mastectomy,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3=Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protocol modification, write in ________________________________</th>
</tr>
</thead>
</table>
0= No, 1= Yes
2=Incomplete/ refused

TECH13
Respiratory Disease Questionnaire. Technician Administered.

Respiratory Diagnoses

<table>
<thead>
<tr>
<th>Examiner ID</th>
</tr>
</thead>
</table>

1. Since your last exam have you had asthma?
   - 0=No
   - 1=Yes
   - If yes, fill ☐
     - Do you still have it?
     - Was it diagnosed by a doctor or other health professional?
     - At what age did it start? (Age in years) 1=Yes
     - If you no longer have it, at what age did it stop? (Age in years) 88=N/A
     - Have you received medical treatment for this in the past 12 months?

2. Since your last exam have you had hay fever (allergy involving the nose and/or eyes)?
   - 0=No
   - 1=Yes

3. Since your last exam have you had pneumonia (including bronchopneumonia)?

4. Since your last exam have you had .... Condition? Health professional DX? Age condition began
   - (0=No, 1=Yes)
   - 99=Unk
   | Chronic Bronchitis | ☐ | ☐ | ☐ | ☐ |
   | Emphysema | ☐ | ☐ | ☐ |
   | COPD       | ☐ | ☐ | ☐ |
   | Chronic obstructive pulmonary disease | ☐ | ☐ | ☐ |
   | Sleep Apnea | ☐ | ☐ | ☐ |
   | Pulmonary Fibrosis | ☐ | ☐ | ☐ |

Inhaler Use

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

TECH14
Respiratory Disease Questionnaire. Technician Administered.

<table>
<thead>
<tr>
<th>Triggered airway symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. When you are near animals, such as cats, dogs, or horses, near feathers, including pillows, quilts, or in a dusty or moldy part of the house, do you ever</strong></td>
</tr>
<tr>
<td>□ Start to cough?</td>
</tr>
<tr>
<td>□ Start to wheeze?</td>
</tr>
<tr>
<td>□ Get a feeling of tightness in your chest?</td>
</tr>
<tr>
<td>□ Start to feel short of breath?</td>
</tr>
<tr>
<td>□ Get a runny or stuffy nose or start to sneeze?</td>
</tr>
<tr>
<td>□ Get itching or watering eyes?</td>
</tr>
<tr>
<td><strong>2. When you are near trees, grass, or flowers, or when there is a lot of pollen in the air, do you ever</strong></td>
</tr>
<tr>
<td>□ Start to cough?</td>
</tr>
<tr>
<td>□ Start to wheeze?</td>
</tr>
<tr>
<td>□ Get a feeling of tightness in your chest?</td>
</tr>
<tr>
<td>□ Start to feel short of breath?</td>
</tr>
<tr>
<td>□ Get a runny or stuffy nose or start to sneeze?</td>
</tr>
<tr>
<td>□ Get itching or watering eyes?</td>
</tr>
<tr>
<td><strong>3. Do you currently have a cat, dog, or other furry pets living in your home?</strong></td>
</tr>
</tbody>
</table>

TECH15
# Proxy form

OMB NO=0925-0216   12/31/2007

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

TECH016
### Sociodemographic questions. Part I  Self-administered

<table>
<thead>
<tr>
<th>OMB NO=0925-0216 12/31/2007</th>
</tr>
</thead>
</table>

#### What is your current marital status?
- 1= single/never married, 
- 2= married/living as married/living with partner
- 3= separated
- 4= divorced
- 5= widowed
- 9= prefer not to answer

#### Which of the following best describes you?

**Ethnicity** (check which applies)
- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino

**Race:** (check ALL that apply)
- [ ] Caucasian or white
- [ ] African-American or black
- [ ] Asian
- [ ] Native Hawaiian or other Pacific Islander
- [ ] American Indian or Alaska native
- [ ] prefer not to answer

#### What is the highest degree or level of school you have completed?
(if currently enrolled, mark the highest grade completed, degree received)
- 0= no schooling
- 1= grades 1-8
- 2= grades 9-11
- 3= completed high school (12th grade) or GED
- 4= some college but no degree
- 5= technical school certificate
- 6= associate degree (Junior college AA, AS)
- 7= Bachelor’s degree (BA, AB, BS)
- 8= graduate or professional degree (master’s, doctorate, MD, etc.)
- 9= prefer not to answer

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

- 0= homemaker, not working outside the home
- 1= employed (or self-employed) full time
- 2= employed (or self-employed) part time
- 3= employed, but on leave for health reasons
- 4= employed, but temporarily away from my job
- 5= unemployed or laid off or full-time student
- 6= retired from my usual occupation and not working
- 7= retired from my usual occupation but working for pay
- 8= retired from my usual occupation but volunteering
- 9= prefer not to answer
- 10= unemployed due to disability
Sociodemographic questions. Part II. Self-administered

What is your current occupation? Write in

Using the occupation coding sheet choose the code that best describes your occupation.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Do you have some form of health insurance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td>Do you have prescription drug coverage?</td>
</tr>
</tbody>
</table>

TECH18
SF-12® Health Survey (Standard)
Self-administered

OMB NO=0925-0216    12/31/2007

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

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

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

   Excellent [ ]
   Very good [ ]
   Good [ ]
   Fair [ ]
   Poor [ ]

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
   Yes, limited a lot [ ]
   Yes, limited a little [ ]
   No, not limited at all [ ]

3. Climbing several flights of stairs
   Yes, limited a lot [ ]
   Yes, limited a little [ ]
   No, not limited at all [ ]

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like
   Yes [ ]
   No [ ]

5. Were limited in the kind of work or other activities
   Yes [ ]
   No [ ]

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

6. Accomplished less than you would like
   Yes [ ]
   No [ ]

7. Didn’t do work or other activities as carefully as usual
   Yes [ ]
   No [ ]

TECH19
8. During the past 4 weeks, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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...

9. Have you felt calm and peaceful?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>A good bit of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Did you have a lot of energy?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>A good bit of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. Have you felt downhearted and blue?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>A good bit of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.)?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TECH20
Sleep Questionnaire. Part 1
Self-administered

How much sleep do you usually get at night (or your main sleep period) on weekdays or work days? (Number of hours)

How long does it usually take you to fall asleep at bedtime? (Number of hours, 1=1 hour or less)

Sleep Related Symptoms (days/night)

In the past 12 months, how often do you snore while you are sleeping?

In the past 12 months, how often do you snort, gasp, or stop breathing while you are asleep?

0=Never
1=Rarely (1-2 nights/week)
2=Occasionally (3-4 nights/week)
3=Frequently (5+ nights/week)
9=Don't know

Please indicate how often in the past month you experienced each of the following.
(Circle one response for each item)

Never  Rarely (1/month or less)  Sometimes (2-4/month)  Often (5-15/month)  Almost always (16-30/month)

Have trouble falling asleep

Wake up during the night and have trouble getting back to sleep.

Wake up too early in the morning and be unable to get back to sleep.

Feel excessively (or overly) sleepy during the day.

TECH21
Sleep Questionnaire. Part 2
Self-administered

<table>
<thead>
<tr>
<th>What is the chance that you would doze off or fall asleep (not just “feel tired”) in each of the following situations? (Circle one response for each situation. If you are never or rarely in the situation, please give your best guess for that situation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situations</td>
</tr>
<tr>
<td>Sitting and reading</td>
</tr>
<tr>
<td>Watching TV.</td>
</tr>
<tr>
<td>Sitting inactive in a public place (such as theater or a meeting)</td>
</tr>
<tr>
<td>Riding as a passenger in a car for an hour without a break.</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit.</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol.</td>
</tr>
<tr>
<td>In a car, while stopped in traffic for a few minutes.</td>
</tr>
<tr>
<td>At the dinner table.</td>
</tr>
<tr>
<td>While driving</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you ever been told by a doctor or other health professional that you have any of the following? (Circle one response for each item)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Items</td>
</tr>
<tr>
<td>Sleep apnea or obstructive sleep apnea.</td>
</tr>
<tr>
<td>Insomnia.</td>
</tr>
<tr>
<td>Restless legs.</td>
</tr>
</tbody>
</table>

TECH22
# Vascular Testing

**Exam 8**
Framingham Study Vascular Function Participant Worksheet

<table>
<thead>
<tr>
<th>Keyer 1: ________________</th>
<th>Keyer 2: ________________</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0</strong></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td>If yes,</td>
<td>discontinue PAT</td>
</tr>
</tbody>
</table>

Do you have a latex allergy? (0=No, 1=Yes, 9=Unknown)

<table>
<thead>
<tr>
<th><strong>0</strong></th>
<th><strong>1</strong></th>
<th><strong>9</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes,</td>
<td>discontinue brachial</td>
<td></td>
</tr>
</tbody>
</table>

Do you have active Raynaud's disease, as manifested by daily attacks of Raynaud's currently blue fingers or ischemic finger ulcers? (0=No, 1=Yes, 9=Unknown)

<table>
<thead>
<tr>
<th><strong>0</strong></th>
<th><strong>1</strong></th>
<th><strong>2</strong></th>
<th><strong>3</strong></th>
<th><strong>8</strong></th>
<th><strong>9</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>If 1(right),</td>
<td>discontinue brachial</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If 2(left),</td>
<td>BP on right</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Women Only:** Have you had a radical mastectomy on right side? A radical mastectomy is the removal of the breast, associated lymph nodes, and underlying musculature. Does NOT include lumpectomy or simple mastectomy. (0=No, 1=Yes, right, 2=Yes, left, 3=Yes, both, 8=Male, 9=Unknown)

<table>
<thead>
<tr>
<th><strong>0</strong></th>
<th><strong>1</strong></th>
<th><strong>9</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>if yes,</td>
<td>fill</td>
<td></td>
</tr>
</tbody>
</table>

Have you had any caffeinated drinks in the last 6 hours? (0=No, 1=Yes, 9=Unknown)

| __ | __ | How many cups? |
|____|____|____|

<table>
<thead>
<tr>
<th><strong>0</strong></th>
<th><strong>1</strong></th>
<th><strong>9</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>if yes,</td>
<td>fill</td>
<td></td>
</tr>
</tbody>
</table>

Have you eaten anything else including a fat free cereal bar this morning? (0=No, 1=Yes, 9=Unknown)

<table>
<thead>
<tr>
<th><strong>0</strong></th>
<th><strong>1</strong></th>
<th><strong>9</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>if yes,</td>
<td>fill</td>
<td></td>
</tr>
</tbody>
</table>

Have you smoked cigarettes in the last 6 hours? (0=No, 1=Yes, 9=Unkn)

| __ | __ | __ |
|____|____|____|
| if yes, | how many hours and minutes since your last cigarette? |

<table>
<thead>
<tr>
<th><strong>0</strong></th>
<th><strong>1</strong></th>
<th><strong>9</strong></th>
</tr>
</thead>
</table>

**PAT SCAN**

| __ | __ | __ | __ | __ | __ | __ | __ |
|____|____|____|____|____|____|____|____|

Date of PAT scan? (mo/day/yr)

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**PAT Sonographer ID**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**Room temperature** (Celsius)

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**Mean systolic baseline blood pressure**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**Cuff inflation pressure** (Baseline SBP + 50 or 250)

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>0</strong></th>
<th><strong>1</strong></th>
<th><strong>2</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>if no (0) or partial (2)</td>
<td>fill</td>
<td></td>
</tr>
</tbody>
</table>

Was PAT protocol completed? (Determined at time of scan or at time of interpreting)

0=No: protocol was not completed i.e. none of 3 parts completed of Baseline, Doppler, Deflation.

1=Yes: protocol was done and completed i.e. all 3 parts completed of Baseline, Doppler, Deflation

2=Yes, Partial: protocol was partially completed i.e. 1 part of 3 completed, 2 of 3 completed of Baseline, Doppler, Deflation

PAT scan deviations: circle ALL that apply

1: Subject refusal

2: Subject discomfort

3: Time constraint

4: Equipment problem (if not #5 or #6), specify ____________________________

5: Foot pedal problem/cuff sequence problem

6: Doppler problem

7: Other, specify ____________________________
## Tonometry

<table>
<thead>
<tr>
<th>Date of tonometry scan?</th>
<th>Mo/Day/Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tonometry Sonographer ID</td>
<td></td>
</tr>
<tr>
<td>Tonometry CD number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was tonometry done?</td>
<td></td>
</tr>
<tr>
<td>0 = No, test was not attempted or done</td>
<td></td>
</tr>
<tr>
<td>1 = Yes, test was done, even if all 4 pulses could not be acquired and recorded.</td>
<td></td>
</tr>
</tbody>
</table>

### Distances:

- Carotid(mm)
- Brachial(mm)
- Radial(mm)
- Femoral(mm)

*Not for Data Entry.*
**FHS ECHOCARDIOGRAPHY ULTRASONOGRAPHER WORKSHEET**

**Study Date** __/__/___  **Study type** 0 1 2 (0=exam, 1=repeat study, 2=other)  **EXAM** __

**Data entry date** __/__/___ ; __/__/___  **Data entry ID** __________ 1st __________ 2nd

**ECHO done?** ~ Yes=1  ~ No=0  **Room #** 106 108  **Tech ID** __ __  **Height (inches)** __ __  **Sex** M F

**Video MOD #** if no video MOD, code 0  **SVHS #** if no SVHS#, code 0  **SVHS location**

**Images available for measuring:** ~ Video images ONLY  ~ Digital images ONLY
(If neither box is checked, then both video and digital images were available for measuring)

---

### STUDY QUALITY

<table>
<thead>
<tr>
<th>Quantitative</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>M-mode Ao/LA</td>
<td>~ =1</td>
<td>~ =2</td>
<td>~ =3</td>
<td>~ =4</td>
</tr>
<tr>
<td>M-mode LV</td>
<td>~ =1</td>
<td>~ =2</td>
<td>~ =3</td>
<td>~ =4</td>
</tr>
<tr>
<td>2-D LV</td>
<td>~ =1</td>
<td>~ =2</td>
<td>~ =3</td>
<td>~ =4</td>
</tr>
<tr>
<td>PW mitral inflow</td>
<td>~ =1</td>
<td>~ =2</td>
<td>~ =3</td>
<td>~ =4</td>
</tr>
</tbody>
</table>

#### Qualitative

- **2-D study** ~ =1  ~ =2  ~ =3  ~ =4
- **CW AV** ~ =1  ~ =2  ~ =3  ~ =4
- **Color Doppler** ~ =1  ~ =2  ~ =3  ~ =4

#### Overall study quality

~ =1  ~ =2  ~ =3  ~ =4

**Comments:**

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

~~ Priority MD overread:  

~~ Severe AS  ~ Severe MS  ~ Mod-severe  

~~ _____regurgitation  

~~ Thrombus  ~ Vegetation  ~ Mass  

~~ Large pericardial effusion  ~ Significant LV dysfunction≤30 % LVEF  

will call MD if Pt. not known to have cardiomyopathy or prior MI  

~~ Other  

Called Dr. ____________________________  

~ Ventricular wall thickness≥15 mm  

Date/time: _______  

~~ MD overread, other:  

~~ > Mild LAE  ~ > Mild AoR dil.  ~ RA/RV abnormality  

~~ Any LVH  ~ Any LVE  ~ LV WMA  9 LVEF  

~~ MS  ~ > Mild MAC  ~ Any MVP  

~~ AS  ~ Bicuspid AV  ~ Valve prosthesis  

~~ > Mild _____regurgitation  

~~ Other  

Requested by: ____________________________  

For: ____________________________  

Dr. ____________________________  

Date: ____________________________  

Reader __ __ __ OverReader __ __ __  

Reading 1 2  

Date interpreted __/__/____  

(mo/day/yr)
<table>
<thead>
<tr>
<th>LA enlargement</th>
<th>~ 0=no</th>
<th>~ 1=borderln.</th>
<th>~ 2=mild</th>
<th>~ 3=moderate</th>
<th>~ 4=severe</th>
<th>~ 9=unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other LA comment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mitral Valve</th>
<th>~ 0=normal</th>
<th>~ 1=prob nl</th>
<th>~ 2=abnormal</th>
<th>~ 4=prosth.</th>
<th>~ 9=unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>MV thickening</td>
<td>~ 0=no</td>
<td>~ 1=minimal</td>
<td>~ 2=mild</td>
<td>~ 3=moderate</td>
<td>~ 4=severe</td>
</tr>
<tr>
<td>MS</td>
<td>~ 0=normal</td>
<td>~ 1=possible</td>
<td>~ 2=likely</td>
<td>~ 3=moderate</td>
<td>~ 4=severe</td>
</tr>
<tr>
<td>MAC</td>
<td>~ 0=no</td>
<td>~ 1=minimal</td>
<td>~ 2=mild</td>
<td>~ 3=moderate</td>
<td>~ 4=severe</td>
</tr>
<tr>
<td>MVP</td>
<td>~ 0=no</td>
<td>~ 1=minimal</td>
<td>~ 2=mild</td>
<td>~ 3=moderate</td>
<td>~ 4=severe</td>
</tr>
<tr>
<td>Other MV comment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aortic Valve</th>
<th>~ 0=normal</th>
<th>~ 1=prob nl</th>
<th>~ 2=abnormal</th>
<th>~ 4=prosth.</th>
<th>~ 9=unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>AV thickening</td>
<td>~ 0=no</td>
<td>~ 1=minimal</td>
<td>~ 2=mild</td>
<td>~ 3=moderate</td>
<td>~ 4=severe</td>
</tr>
<tr>
<td>AV cusp excursion</td>
<td>~ 0=normal</td>
<td>~ 1=yes</td>
<td>~ 2=maybe</td>
<td>~ 3=moderate</td>
<td>~ 4=severe</td>
</tr>
<tr>
<td>Bicuspid AoV</td>
<td>~ 0=normal</td>
<td>~ 1=prob nl</td>
<td>~ 2=abnormal</td>
<td>~ 9=unknown</td>
<td></td>
</tr>
<tr>
<td>Aortic Root</td>
<td>~ 0=normal</td>
<td>~ 1=prob nl</td>
<td>~ 2=abnormal</td>
<td>~ 9=unknown</td>
<td></td>
</tr>
<tr>
<td>Aortic root dilatation</td>
<td>~ 0=no</td>
<td>~ 1=minimal</td>
<td>~ 2=mild</td>
<td>~ 3=moderate</td>
<td>~ 4=severe</td>
</tr>
<tr>
<td>Aortic root calcium</td>
<td>~ 0=no</td>
<td>~ 1=minimal</td>
<td>~ 2=mild</td>
<td>~ 3=moderate</td>
<td>~ 4=severe</td>
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<tr>
<td>Other AV/AR comment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LV Structure</th>
<th>~ 0=normal</th>
<th>~ 1=prob nl</th>
<th>~ 2=abnormal</th>
<th>~ 3=moderate</th>
<th>~ 4=severe</th>
<th>~ 9=unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>LV enlargement</td>
<td>~ 0=no</td>
<td>~ 1=borderline</td>
<td>~ 2=mild</td>
<td>~ 3=moderate</td>
<td>~ 4=severe</td>
<td>~ 9=unknown</td>
</tr>
<tr>
<td>LVWVT, concentric</td>
<td>~ 0=no</td>
<td>~ 1=borderline</td>
<td>~ 2=mild</td>
<td>~ 3=moderate</td>
<td>~ 4=severe</td>
<td>~ 9=unknown</td>
</tr>
<tr>
<td>LVWVT, other</td>
<td>~ 0=no</td>
<td>~ 1=DUSK</td>
<td>~ 2=ASH</td>
<td>~ 3=ISH</td>
<td>~ 4=oth</td>
<td>~ 9=unknown</td>
</tr>
<tr>
<td>LV Regional WMA</td>
<td>~ 0=normal</td>
<td>~ 1=prob nl</td>
<td>~ 2=abnormal</td>
<td>~ 9=unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Septum</td>
<td>~ 0=normal</td>
<td>~ 1=paradoxic</td>
<td>~ 2=hypokinetic</td>
<td>~ 3=akinetic</td>
<td>~ 4=dyskinetic</td>
<td>~ 9=unknown</td>
</tr>
<tr>
<td>Anterior</td>
<td>~ 0=normal</td>
<td>~ 1=borderline</td>
<td>~ 2=hypokinetic</td>
<td>~ 3=akinetic</td>
<td>~ 4=dyskinetic</td>
<td>~ 9=unknown</td>
</tr>
<tr>
<td>Anterior/Anterolateral</td>
<td>~ 0=normal</td>
<td>~ 1=borderline</td>
<td>~ 2=hypokinetic</td>
<td>~ 3=akinetic</td>
<td>~ 4=dyskinetic</td>
<td>~ 9=unknown</td>
</tr>
<tr>
<td>Posterior</td>
<td>~ 0=normal</td>
<td>~ 1=borderline</td>
<td>~ 2=hypokinetic</td>
<td>~ 3=akinetic</td>
<td>~ 4=dyskinetic</td>
<td>~ 9=unknown</td>
</tr>
<tr>
<td>Inferior</td>
<td>~ 0=normal</td>
<td>~ 1=borderline</td>
<td>~ 2=hypokinetic</td>
<td>~ 3=akinetic</td>
<td>~ 4=dyskinetic</td>
<td>~ 9=unknown</td>
</tr>
<tr>
<td>Apex</td>
<td>~ 0=normal</td>
<td>~ 1=borderline</td>
<td>~ 2=hypokinetic</td>
<td>~ 3=akinetic</td>
<td>~ 4=dyskinetic</td>
<td>~ 9=unknown</td>
</tr>
<tr>
<td>LV Systolic Function</td>
<td>~ 0=normal</td>
<td>~ 1=prob nl</td>
<td>~ 2=regional</td>
<td>~ 4=global</td>
<td>~ 9=unknown</td>
<td></td>
</tr>
<tr>
<td>LV ejection fraction</td>
<td>~ 0=normal</td>
<td>~ 1=borderline</td>
<td>~ 2=mild</td>
<td>~ 3=moderate</td>
<td>~ 4=severe</td>
<td>~ 9=unknown</td>
</tr>
<tr>
<td>Other LV comment</td>
<td></td>
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<tr>
<td>LVEF ___ %</td>
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</tbody>
</table>

| Right Heart/Pericardium | ~ 0=normal | ~ 1=prob nl | ~ 2=abnormal | ~ 9=unknown |
| RA enlargement | ~ 0=no | ~ 1=borderline | ~ 2=mild | ~ 3=moderate | ~ 4=severe | ~ 9=unknown |
| RV enlargement | ~ 0=no | ~ 1=borderline | ~ 2=mild | ~ 3=moderate | ~ 4=severe | ~ 9=unknown |
| RV hypertrophy | ~ 0=no/syst. | ~ 2=small | ~ 3=medium | ~ 4=large | ~ 9=unknown |
| Other right heart/pericardium |          |               |          |              |           |            |

| Valve Regurgitation | ~ 0=none | ~ 1=trace | ~ 2=present | ~ 4=moderate | ~ 9=unknown |
| Mitral | ~ 0=none | ~ 1=trace | ~ 2=mild | ~ 3=moderate | ~ 4=moderate | ~ 9=unknown |
| Aortic | ~ 0=none | ~ 1=trace | ~ 2=mild | ~ 3=moderate | ~ 4=moderate | ~ 9=unknown |
| Tricuspid | ~ 0=none | ~ 1=trace | ~ 2=mild | ~ 3=moderate | ~ 4=moderate | ~ 9=unknown |
| Mitral Stenosis | ~ 0=none | ~ 1=trivial | ~ 2=mild | ~ 3=moderate | ~ 4=severe | ~ 9=unknown |
| Aortic Stenosis | ~ 0=none | ~ 1=trivial | ~ 2=mild | ~ 3=moderate | ~ 4=severe | ~ 9=unknown |
| Other Doppler comment |          |               |          |              |           |            |

Comments:__________________________________________

| Clinical correlation is suggested | ~ 0=not applicable | ~ 1=yes |
| Technically limited study | ~ 0=no | ~ 1=yes |

Version #8  GM  09-27-05
## OFFSPRING EXAM 8 LOG BOOK SHEET FOR TONOMETRY, PAT AND ECHO TESTS

OMB NO=0925-0216  12/31/2007

<table>
<thead>
<tr>
<th>Date of Clinic Visit</th>
<th>Room #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo  Day  Yr</td>
<td>106 108</td>
</tr>
</tbody>
</table>

### TONOMETRY

<table>
<thead>
<tr>
<th>Test done?</th>
<th>yes (test was done, even if all 4 pulses could not be acquired and recorded)</th>
<th>no (test was not attempted or done)</th>
<th>If no , why: Circle all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. Subject refusal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Subject discomfort</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Time constraint</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. Equipment problem, specify</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>30 49 88 740</th>
<th>Sonographer ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>750 54 ______</td>
<td>Video CD#</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>/<strong><strong>/</strong></strong></th>
<th>TONOMETRY test date if different from Clinic Date above.</th>
</tr>
</thead>
</table>

### ECHO

<table>
<thead>
<tr>
<th>Test done?</th>
<th>yes (test was done, even if recorded on video only)</th>
<th>yes, partial (i.e. only apical OR only parasternal images were acquired)</th>
<th>no (test was not attempted or done)</th>
<th>If no or partial, why: Circle all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. Subject refusal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Subject discomfort</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Time constraint</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. Equipment problem, specify</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>30 49 88 740</th>
<th>Sonographer ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>750</td>
<td>SVHS#</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>/<strong><strong>/</strong></strong></th>
<th>ECHO test date if different from Clinic Date above.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MD overread required:</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
</table>

### PAT

<table>
<thead>
<tr>
<th>Test done?</th>
<th>yes (test was attempted)</th>
<th>yes, partial (yes, partial test was done but suspect data problems)</th>
<th>no (test was not attempted or done)</th>
<th>If no or partial, why: Circle all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. Subject refusal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Subject discomfort</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Time constraint</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. Equipment problem, specify</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5. test contraindication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7. Other, specify</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8. Latex allergy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>30 49 88 740</th>
<th>Sonographer ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>750 54 ______</td>
<td>Video CD#</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>/<strong><strong>/</strong></strong></th>
<th>PAT test date if different from Clinic Date above.</th>
</tr>
</thead>
</table>

Version #8  GM  09-27-05
Framingham Heart Study
Offspring Exam 8

Summary Sheet to Personal Physician

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>First Reading</th>
<th>Second Reading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diastolic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ECG Diagnosis ____________________________________________________________

The following tests are done on a routine basis: Blood Glucose, Blood Lipids, Pulmonary Function Test (results enclosed); Echocardiogram findings will be forwarded at a later date only if abnormal.

Summary of Findings

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

Examining Physician

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

OMB NO=0925-0216    12/31/2007

Was further medical evaluation recommended for this participant?  
0=No, 1=Yes, 9=Unknown

RESULT Reason for further evaluation: 0=No, 1=Yes, 9=Unknown

Blood Pressure

- Phone call > 200/110
- Expedite ≥ 180/100
- Elevated > 140/90

Abnormal Urine

Write in abnormality

ECG abnormality

Clinic Physician

identified medical problem

Other

Technician ID#

Was there an adverse event in clinic/offsite that does not require further medical evaluation? (0=No, 1=Yes, 9=Unknown)

Comments:

Technician ID# (OFFSITE visits only)

Was a FHS physician contacted during the examination due to adverse exam finding? (0=No, 1=Yes, 9=Unknown)

Comments:

TECH23
### Method used to inform participant of need for further medical evaluation

<table>
<thead>
<tr>
<th></th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Face-to-face in clinic</td>
</tr>
<tr>
<td>2</td>
<td>Phone call</td>
</tr>
<tr>
<td>3</td>
<td>Result letter</td>
</tr>
<tr>
<td>4</td>
<td>Other</td>
</tr>
</tbody>
</table>

### Method used to inform participant’s personal physician of need for further medical evaluation

<table>
<thead>
<tr>
<th></th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Phone call</td>
</tr>
<tr>
<td>2</td>
<td>Result letter mailed</td>
</tr>
<tr>
<td>3</td>
<td>Result letter FAX’d</td>
</tr>
<tr>
<td>4</td>
<td>Other</td>
</tr>
</tbody>
</table>

**Date referral made:** __/__/______  Use 4 digits for year

**ID number of person completing the referral:** __________

**Notes documenting conversation with participant or participant’s personal physician:** ________________

_____________________________________________________________________________________

_____________________________________________________________________________________

TECH24
### Medical History—Hospitalizations, ER Visits, MD Visits

**Offspring EXAM 8**

**DATE ____________**

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

**Last exam on:** «LExam»

**Last Health History Update on:** «LUpdate»

<table>
<thead>
<tr>
<th>0</th>
<th>1st Examiner Prefix (0=MD, 1=Tech. for OFFSITE visit)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st Examiner ID __________________________ 1st Examiner Name</td>
</tr>
</tbody>
</table>

|  □ □ □ □ □ | Hospitalization (not just E.R.) since your last exam (0=No; 1=yes, hospitalization, 2=yes, more than 1 hospitalization, 9=Unknown) |
|  □ □ □ □ □ | E.R. Visit since your last exam (0=No; 1=Yes, 1 or more E. Room visit, 9=Unk) |
|  □ □ □ □ □ | Day Surgery (0=No, 1=Yes, 9=Unknown) |
|  □ □ □ □ □ | Major illness with visit to doctor (0=No, 1=Yes, 1 visit; 2=Yes, more than 1 visit; 9=Unk) |
|  □ □ □ □ □ | Have you had a fever or infection in past two weeks? (0=No, 1=Yes, 9=Unknown) |
|  □ □ □ □ □ | Check up by doctor in past 5 years (0=No, 1=Yes, 9=Unknown) |
|  □ □ □ □ □ | Date of this FHS exam (Today's date - See above) |

**Note:** if FHS needs outside hospital record, please obtain details: mo/yr, hospital site.

<table>
<thead>
<tr>
<th>Medical Encounter</th>
<th>Month/Year (of last visit)</th>
<th>Site of Hospital or Office</th>
<th>Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**MD01**

Version #8  GM  09-27-05
Medical History—Medications

Take aspirin regularly? (0=No, 1=Yes, 9=Unk)

|  | Number aspirins taken regularly (99=Unknown) |
|  | Frequency per (1=Day, 2=Week 3=Month, 4=Year, 9=Unk) |
|  | Usual dose (081=baby,160=half dose, 325=nl, 500=extra or larger,999=unk) |

Since your last exam have you taken medication for hypertension/high blood pressure? (0=no, 1=yes, now, 2=yes, not now, 9=unk)

Since your last exam have you taken medication for high blood cholesterol or high triglycerides? (0=no, 1=yes, now, 2=yes, not now, 9=unk)

Since your last exam have you been told by a doctor you have high blood sugar or diabetes? (0=no, 1=yes, now, 2=yes, not now, 9=unk)

Since your last exam have you taken medication for cardiovascular disease (for example angina/heart pain, heart failure, atrial fibrillation/heart rhythm abnormality, stroke, leg pain when walking? (0=no, 1=yes, now, 2=yes, not now, 9=unk)
Medical History – Prescription and Non-Prescription Medications

OMB NO=0925-0216  12/31/2007

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

<table>
<thead>
<tr>
<th>Medication bottles/packs used by examiner to record medications?</th>
<th>0=No, 1=Yes</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Medication Name (Print first 20 letters)</th>
<th>Strength (include mg, IU, etc)</th>
<th>Number per (day/week/month) (circle one)</th>
<th>Prn (0=no, 1=yes, 9=unknown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAMPLE:</td>
<td></td>
<td>100 mg</td>
<td>1 (D) W M</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>D W M</td>
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</tbody>
</table>

Continue on the next page
Medical History—Prescription and Non-Prescription Medications
Continue from screen 3.

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

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

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

MD04
Medical History–Female Reproductive History. Part 1.

If participant is male, leave questions blank

<table>
<thead>
<tr>
<th></th>
<th>1. Since your last exam have you taken or used oral contraceptive pills, shots, or hormone implants for birth control or medical indications (not post menopausal hormone replacement)? (0=no, 1=yes, now, 2=yes, not now, 9=unknown)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If yes, fill □ What is the name of the <strong>current or most recent</strong> oral contraceptive, shot or implant used?</td>
</tr>
<tr>
<td></td>
<td>____________________________ Name</td>
</tr>
<tr>
<td></td>
<td>______________ Strength</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>/_______, <strong>/</strong></strong>___ Duration of use (mo/yr began, mo/yr ended, year – 4 digits)</td>
</tr>
<tr>
<td></td>
<td>99/9999=Unknown, 88/8888=current user</td>
</tr>
<tr>
<td></td>
<td>2. Have you had a hysterectomy (uterus/womb removed) since your last exam? (0=no, 1=yes, 9=unknown)</td>
</tr>
<tr>
<td></td>
<td>If yes, fill □ Age at hysterectomy?</td>
</tr>
<tr>
<td></td>
<td><strong>/_/</strong>___ Date of surgery (mo/yr) Use 4 digits for year 99/9999=Unknown</td>
</tr>
<tr>
<td></td>
<td>3. Since your last exam have you had an operation to remove one or both of your ovaries? (0=no, 1=yes, one ovary removed, 2=yes, two ovaries removed, 3=yes, unknown number of ovaries removed, 4=yes, part of an ovary removed, 9=unknown)</td>
</tr>
<tr>
<td></td>
<td>If yes, fill □ Age when ovaries removed? If more than one surgery, use age at last surgery</td>
</tr>
</tbody>
</table>

MD05
# Medical History–Female Reproductive History. Part 2.

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

4. Have your periods stopped (for one year or more)? (Have you reached menopause?)

(0=not stopped, pregnant, breast feeding, 1=stopped but now have periods induced by hormones, 2=yes stopped>1 year, 3=yes stopped<1 year, 9=unknown)

*Please fill in only one of the boxes below, not both!*

<table>
<thead>
<tr>
<th>IF PERIODS NOT STOPPED (pre-menopausal, pregnant, breast feeding!)</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was the first day of your last menstrual period? (Use 4 digits for year, 99/9999=Unknown)</td>
</tr>
<tr>
<td>How many periods have you had in past 12 months?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IF PERIODS STOPPED (post-menopausal, post-menopausal on hormone replacement, or peri-menopausal on horm.repl.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Age when periods stopped (00=not stopped, 99=unknown)! If periods now induced by hormones, code age when periods naturally stopped.</td>
</tr>
<tr>
<td>b) Was your menopause natural or the result of surgery, chemotherapy, or radiation? (1=natural, 2=surgical, 3=chemo/radiation, 4=other, 9=unknown)</td>
</tr>
<tr>
<td>c) Since your last exam have you taken hormone replacement therapy? (estrogen/progesterone) (0=no, 1=yes, now, 2=yes, not now, 9=unknown)</td>
</tr>
<tr>
<td>What age did you begin hormone replacement therapy? 99=unknown</td>
</tr>
<tr>
<td>For how long did you take hormones? 99/99=unknown</td>
</tr>
<tr>
<td>Estrogen use? (0=no, 1=yes, now, 2=yes, not now, 9=unknown)</td>
</tr>
<tr>
<td>Name of most recent estrogen preparation</td>
</tr>
<tr>
<td>Strength</td>
</tr>
<tr>
<td>Number of days per month taken</td>
</tr>
<tr>
<td>Progesterone use? (0=no, 1=yes, now, 2=yes, not now, 9=unknown)</td>
</tr>
<tr>
<td>Name of most recent progesterone preparation</td>
</tr>
<tr>
<td>Strength</td>
</tr>
<tr>
<td>Number of days per month taken</td>
</tr>
<tr>
<td>d) Have you used Evista (raloxifene) or Nolvadex (tamoxifen) or other selective estrogen receptor Modulator (SERM)? (0=no, 1=yes, now, 2=yes, not now, 9=unknown)</td>
</tr>
<tr>
<td>Number of months used?</td>
</tr>
<tr>
<td>Current use? (0=no, 1=yes, raloxifene, 2=yes, tamoxifen, 3=yes, other, 9=unknown)</td>
</tr>
</tbody>
</table>

MD06
# Medical History—Smoking

**Cigarettes**

<table>
<thead>
<tr>
<th></th>
<th>Since your last exam have you smoked cigarettes regularly? (No means less than 1 cigarette a day for 1 year.) (0=no, 1=yes, 9=unk)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Have you smoked cigarettes regularly in the last year?</td>
</tr>
<tr>
<td></td>
<td>Do you now smoke cigarettes (as of 1 month ago)?</td>
</tr>
<tr>
<td></td>
<td>How many cigarettes do you smoke per day now?</td>
</tr>
<tr>
<td></td>
<td>On average, since your last exam, how many cigarettes did you smoke per day?</td>
</tr>
<tr>
<td></td>
<td>How old were you when you first started regular cigarette smoking? (99=Unk.)</td>
</tr>
<tr>
<td></td>
<td>If you have stopped smoking cigarettes completely, how old were you when you stopped?</td>
</tr>
<tr>
<td></td>
<td>(Age stopped, 00=not stopped, 99=Unk)</td>
</tr>
<tr>
<td></td>
<td>During the time you were smoking since your last exam, did you ever stop smoking for &gt;6 months?</td>
</tr>
<tr>
<td></td>
<td>During the time since your last exam, for how many years in total did you stop smoking cigarettes (00=never stopped)</td>
</tr>
</tbody>
</table>

**Other**

<table>
<thead>
<tr>
<th></th>
<th>Since your last exam, have you regularly smoked a pipe or cigar?</th>
<th>0=No</th>
<th>1=Yes</th>
<th>9=Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do you smoke a pipe or cigar now</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MD07
Medical History – Alcohol Consumption.

In the interim did you drink any of the following beverages at least once a month?

<table>
<thead>
<tr>
<th>Drink?</th>
<th>Beverage</th>
<th>If yes, complete for number of drinks in a typical week/month over past year. Code EITHER per week OR per month as appropriate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 9=Ukn</td>
<td>12oz bottle, glass, can</td>
<td>Per week OR Per month 999=Unk</td>
</tr>
<tr>
<td>B</td>
<td>Beer</td>
<td>12oz bottle, glass, can</td>
</tr>
<tr>
<td>B</td>
<td>Wine</td>
<td>4oz glass</td>
</tr>
<tr>
<td>B</td>
<td>Liquor/spirits</td>
<td>1 _ oz jigger</td>
</tr>
</tbody>
</table>

At what age did you stop drinking alcohol? (00= not stopped, 888=never drank 99=Unknown)

Over the past year, on average on how many days per week did you drink an alcoholic beverage of any type? (1=1 or less, 9=Unknown)

Over the past year, on a typical day when you drink, how many drinks do you have? (99=Unknown)

What was the maximum number of drinks you had in 24 hr. period during the past month? (99=Unknown)

Has there ever been a time in your life when you drank 5 or more alcoholic drinks of any kind almost daily? (0=no, 1=yes, 9=unknown)

MD08
### Medical History—Respiratory Symptoms. Part I

**Cough**

<table>
<thead>
<tr>
<th></th>
<th>Do you usually have a cough? (Exclude clearing of the throat)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0=No 1=Yes 9=Don’t know</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Do you usually have a cough at all on getting up or first thing in the morning?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0=No 1=Yes 9=Don’t know</td>
</tr>
</tbody>
</table>

If YES to either question above answer the following:

<table>
<thead>
<tr>
<th></th>
<th>Do you cough like this on most days for three consecutive months or more during the past year?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0=No 1=Yes 9=Don’t know</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>How many years have you had this cough? (99=Unk.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of years</td>
</tr>
</tbody>
</table>

**Phlegm**

<table>
<thead>
<tr>
<th></th>
<th>Do you usually bring up phlegm from your chest?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0=No 1=Yes 9=Don’t know</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Do you usually bring up phlegm at all on getting up or first thing in the morning?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0=No 1=Yes 9=Don’t know</td>
</tr>
</tbody>
</table>

If YES to either question above answer the following:

<table>
<thead>
<tr>
<th></th>
<th>Do you bring up phlegm from your chest on most days (4 or more days/week) for three consecutive months or more during the year?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0=No 1=Yes 9=Don’t know</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>How many years have you had trouble with phlegm? (99=Unk.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of years</td>
</tr>
</tbody>
</table>

**Wheeze**

<table>
<thead>
<tr>
<th></th>
<th>In the last 12 months, have you had wheezing or whistling in your chest at any time?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0=No 1=Yes 9=Don’t know</td>
</tr>
</tbody>
</table>

If yes, fill all

<table>
<thead>
<tr>
<th></th>
<th>In the last 12 months, how often have you had this wheezing or whistling?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0=Not at all 1=Most days or nights 2=A few days or nights a week 3=A few days or nights a month 4=A few days or nights a year 9=Unknown</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>In the past 12 months, have you had this wheezing or whistling in the chest when you had a cold?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0=No 1=Yes 9=Don’t know</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>In the past 12 months, have you had this wheezing or whistling in the chest apart from colds?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0=No 1=Yes 9=Don’t know</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>In the last 12 months, have you had an attack of wheezing or whistling in the chest that had made you feel short of breath?</th>
</tr>
</thead>
</table>

MD09
Medical History—Respiratory Symptoms. Part II

<table>
<thead>
<tr>
<th>Nocturnal chest symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ In the last 12 months, have you been awakened by shortness of breath?</td>
</tr>
<tr>
<td>□ In the last 12 months, have you been awakened by a wheezing/whistling in your chest?</td>
</tr>
<tr>
<td>□ In the last 12 months, have you been awakened by coughing?</td>
</tr>
<tr>
<td>□ In the last 12 months, how often have you been awakened by coughing?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shortness of breath</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?</td>
</tr>
<tr>
<td>□ Do you have to walk slower than people of your age on level ground because of shortness of breath?</td>
</tr>
<tr>
<td>□ Do you ever have to stop for breath when walking at your own pace on level ground?</td>
</tr>
<tr>
<td>□ Do you ever have to stop for breath after walking 100 yards (or after a few minutes) on level ground?</td>
</tr>
</tbody>
</table>

| Do you/have you needed to sleep on two or more pillows to help you breath? (Orthopnea) |
| Since your last exam have you had swelling in both your ankles (ankle edema)? |
| Since your last exam have you been told you had heart failure or congestive heart failure? |
| Since your last exam have you been hospitalized for heart failure? |

| Examiner’s opinion: |
| □ First examiner believes CHF |

Comments

________________________________________________________________________________
________________________________________________________________________________

MD10
### Physician Blood Pressure
(first reading)

<table>
<thead>
<tr>
<th>Systolic</th>
<th>Diastolic</th>
<th>BP cuff size</th>
<th>Protocol modification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>0=No, 1=Yes, 9=Unknown</td>
</tr>
</tbody>
</table>

0=pedi, 1=reg.adult, 2=large adult, 3=thigh, 9=unknown

Comments on protocol modification

MD11
### Medical History—Chest pain

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>Date of onset</th>
<th>Usual duration</th>
<th>Longest duration</th>
<th>Location</th>
<th>Radiation</th>
<th>Frequency past month</th>
<th>Frequency past year</th>
<th>Type</th>
<th>Relief by Nitroglycerine in &lt;15 minutes</th>
<th>Relief by Rest in &lt;15 minutes</th>
<th>Relief Spontaneously in &lt;15 minutes</th>
<th>Relief by Other cause in &lt;15 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(mo/yr, Use 4 digits for year, 99/9999=Unknown)</td>
<td>(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)</td>
<td>(minutes: 1=1 min or less, 900=15 hrs or more, 999=Unknown)</td>
<td>(0=No, 1=Central sternum and upper chest, 2=L Up Quadrant, 3=L Lower ribcage, 4=R Chest, 5=Other, 6=Combination, 9=Unknown)</td>
<td>(0=No, 1=Left shoulder or L arm, 2=Neck, 3=R shoulder or arm, 4=Back, 5=Abdomen, 6=Other, 7=Combination, 9=Unknown)</td>
<td>999=Unknown</td>
<td>999=Unknown</td>
<td>(1=Pressure, heavy, vise, 2=Sharp, 3=Dull, 4=Other, 9=Unk)</td>
<td>0=No</td>
<td>1=Yes</td>
<td>8=Not tried</td>
<td>9=Unknown</td>
</tr>
</tbody>
</table>

- [ ] Since your last exam have you been told by a doctor you had a heart attack or myocardial infarction?  
  0=No, 1=Yes, 2=Maybe, 9=Unknown

**CHD First Opinions**

<table>
<thead>
<tr>
<th></th>
<th>Angina pectoris</th>
<th>Angina pectoris since revascularization procedure</th>
<th>Coronary insufficiency</th>
<th>Myocardial infarct</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0=No, 1=Yes, 2=Maybe, 9=Unknown)</td>
<td>(0=No, 1=Yes, 2=Maybe, 9=Unknown)</td>
<td>(0=No, 1=Yes, 2=Maybe, 9=Unknown)</td>
<td>(0=No, 1=Yes, 2=Maybe, 9=Unknown)</td>
</tr>
</tbody>
</table>

Comments

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

MD12
### Medical History—Atrial Fibrillation/Syncope

OMB NO=0925-0216  12/31/2007

<table>
<thead>
<tr>
<th>Have you been told you have/had a heart rhythm problem called atrial fibrillation?</th>
<th>Code: 0=No, 1=Yes, 2=Maybe, 9=Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of first episode (99/99/9999=unk) code year as 4 digits, example: Year 1999=1999</td>
<td>ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn)</td>
</tr>
<tr>
<td>Hospitalized at: _____________________________</td>
<td>M.D. seen: _____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Since your last exam have you fainted or lost consciousness?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If event immediately preceded by head injury or accident code 0=No)</td>
</tr>
<tr>
<td>Number of episodes in the past two years (999=Unknown)</td>
</tr>
<tr>
<td>Date of first episode (use 4 digits for year, i.e. 1998)</td>
</tr>
<tr>
<td>Usual duration of loss of consciousness (minutes, 999=Unkn) 1=1 min or less</td>
</tr>
<tr>
<td>Did you have any injury caused by the event? (0=No, 1=Yes, 2=Maybe, 9=Unkn)</td>
</tr>
<tr>
<td>ER/hospitalized or saw M.D. (0=No, 1=Hosp/ER, 2=Saw M.D., 9=Unkn)</td>
</tr>
<tr>
<td>Hospitalized at: _____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History (since your last exam) of having a head injury with loss of consciousness (0=No, 1=Yes, 2=Maybe, 9=Unknown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of serious head injury with loss of consciousness (00/00/0000 =none, 99/99/9999=unk, Use 4 digits for year)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History of a seizure disorder. Since your last exam have you had a seizure? (0=No, 1=Yes, 2=Maybe,, 9=Unknown)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of most recent seizure (99/99/9999=unk) code four digit year</td>
</tr>
<tr>
<td>Are you being treated for a seizure disorder? (0=No, 1=Yes, 2=Maybe, 9=Unknown)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Syncope First Opinions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syncope (0=No, 1=Yes, 2=Maybe, 3=Presyncope, 9=Unknown) needs second opinion</td>
</tr>
<tr>
<td>Cardiac syncope</td>
</tr>
<tr>
<td>Vasovagal syncope (0=No, 1=Yes, 2=Maybe, 9=Unknown)</td>
</tr>
<tr>
<td>Other-Specify: ____________</td>
</tr>
</tbody>
</table>

Comments: _____________________________

MD13
### Medical History—Cerebrovascular, Neurological and Venous Diseases

**O.M.B. No.: 0925-0216** 12/31/2007

#### Cerebrovascular Episodes Since Your Last Exam

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden muscular weakness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudden speech difficulty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudden visual defect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudden double vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudden loss of vision in one eye</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudden numbness, tingling</td>
<td></td>
<td>Numbness and tingling is positional</td>
</tr>
<tr>
<td>Head CT or MRI scan date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head CT or MRI scan place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seen by neurologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been told by a doctor you had a stroke or TIA? (transient ischemic attack, mini-stroke)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been told by a doctor you have Parkinson Disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been told by a doctor you have memory problems, dementia or Alzheimer’s disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Cerebrovascular Disease First Opinions

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIA or stroke took place</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Date**: (mo/yr, Use 4 digits for year, 99/9999=Unkn)
- **Observed by**: 
- **Duration**: (use format days/hours/mins, 99/99/99=Unknown)
- **Hospitalized or saw M.D.**: (0=No, 1=Hosp, 2=Saw M.D, 9=Unkn)

**Neurology Comments**: 
____________________________________________________________________________________________
_______________________________________________________________________________________________________

#### Venous Disease

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Since your last exam have you had a Deep Vein Thrombosis (blood clots in legs or arms)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Since your last exam have you had a Pulmonary Embolus (blood clot in lungs)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MD14**
# Medical History--Peripheral Arterial Disease

## Peripheral Arterial Disease

<table>
<thead>
<tr>
<th></th>
<th>Do you have discomfort in your legs while walking? (0=No, 1=Yes, 9=Unkn)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If yes, fill</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>If walking on level ground, how many city blocks until symptoms develop (00=no, 99=unknown) where 10 blocks=1 mile, code as no if more than 98 blocks required to develop symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year symptoms started (Use 4 digits for year, 00=no, 9999=unkn)</td>
</tr>
</tbody>
</table>

### Claudication symptoms (0=No, 1=Yes, 9=Unkn)

<table>
<thead>
<tr>
<th>Left</th>
<th>Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discomfort in calf while walking</td>
<td></td>
</tr>
<tr>
<td>Discomfort in lower extremity (not calf) while walking</td>
<td></td>
</tr>
<tr>
<td>Occurs with first steps (code worse leg)</td>
<td></td>
</tr>
<tr>
<td>After walking a while (code worse leg)</td>
<td></td>
</tr>
<tr>
<td>Related to rapidity of walking or steepness</td>
<td></td>
</tr>
<tr>
<td>Forced to stop walking</td>
<td></td>
</tr>
<tr>
<td>Time for discomfort to be relieved by stopping (minutes) (00=No relief with stopping, 88=Not Applicable, 99=Unknown)</td>
<td></td>
</tr>
<tr>
<td>Number of days/month of lower limb discomfort (00=No, 88=N/A, 99=Unk.)</td>
<td></td>
</tr>
</tbody>
</table>

### Have you had back pain in the past 12 months?

<table>
<thead>
<tr>
<th></th>
<th>0=No, 1=all days, 2=most of the days, 3=some days, 4=a few days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What happens to back and any leg pain that goes with it when you walk?</td>
</tr>
<tr>
<td></td>
<td>What happens to back and any pain that goes with it when you sit?</td>
</tr>
</tbody>
</table>

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

| | 0=No, 1=Yes, 9=Unknown |

### Has a doctor ever told you you had spinal stenosis?

| | 0=No, 1=Yes, 9=Unknown |

### Have you had a CT or MRI of your spine?

| | Date___-___-____ Location _____________________________ |

## PAD First Opinion

| | 0=No, 1=Yes, 2=Maybe, 9=Unkn. |

### Intermittent Claudication

## Comments Peripheral Vascular Disease / Venous Disease

MD15
### Medical History-- CVD Procedures

**Cardiovascular Procedures**
(if procedure was repeated code only first and provide narrative)
(write 4 digits for year, i.e. 1998, 1999, 2000)

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Heart Valvular Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk) Location and description</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Exercise Tolerance Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk) Location</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Coronary arteriogram</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Coronary artery angioplasty/stent/PCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk) Type of procedure (0=none, 1=balloon, 2=stent, 3=other, 9=unkn)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Coronary bypass surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Permanent pacemaker insertion</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>AICD</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Carotid artery surgery/stent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Thoracic aorta surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Abdominal aorta surgery/stent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Femoral or lower extremity surgery/stent/angioplasty</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Lower extremity amputation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Other Cardiovascular Procedure (write in below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Yes, 2=Maybe, 9=Unkn</td>
<td>If yes, fill</td>
</tr>
<tr>
<td></td>
<td>Year done (9999-Unk) Description</td>
</tr>
</tbody>
</table>

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

Comments: __________________________________________________________________________
____________________________________________________________________________________

MD16
Physician Blood Pressure
(second reading)

<table>
<thead>
<tr>
<th>Systolic</th>
<th>Diastolic</th>
<th>BP cuff size</th>
<th>Protocol modification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Write in protocol modification:

---

Cancer Site or Type

Since your last exam have you had cancer or a tumor?
(0=No and skip to next screen; If 1=Yes, 2=Maybe, 9=Unknown please continue)

<table>
<thead>
<tr>
<th>Code</th>
<th>Site of Cancer or Tumor</th>
<th>Year First Diagnosed</th>
<th>Name Diagnosing M.D.</th>
<th>City of M.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Esophagus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stomach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Colon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rectum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pancreas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Larynx</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trachea/Bronchus/Lung</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leukemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cervix/Uterus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ovary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prostate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bladder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kidney</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lymphoma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other/Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

MD17
## Physical Exam—Respiratory, Heart, Abdomen

### Respiratory

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

### Heart

- **S3 Gallop**
  - 0=No, 1=Yes, 9=Unknown
- **S4 Gallop**
- **Systolic Click**
  - 0=No, 1=Yes, 2=Maybe, 9=Unknown
- **Neck vein distention at 90 degrees**
  - 0=No, 1=Yes, 2=Maybe, 9=Unknown

#### Systolic murmur(s)

- If yes, fill out below

<table>
<thead>
<tr>
<th>Murmur Location</th>
<th>Grade</th>
<th>Type</th>
<th>Radiation</th>
<th>Origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Sternum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Diastolic murmur(s)

- If yes, fill

<table>
<thead>
<tr>
<th>Valve of origin for diastolic murmur(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=No, 1=Mitral, 2=Aortic, 3=Both, 4=Other, 8=N/A, 9=Unk</td>
</tr>
</tbody>
</table>

### Abdominal Abnormalities

- **Liver enlarged**
  - 0=No, 1=Yes, 2=Maybe, 9=Unknown
- **Surgical scar**
- **Abdominal aneurysm**
- **Abdominal bruise**

### Comments about respiratory, heart, and abdominal abnormalities

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________
### Physical Exam--Peripheral Vessels—Veins and Arterial pulses

**OFFSITE VISIT – leave page BLANK**

<table>
<thead>
<tr>
<th></th>
<th>Left</th>
<th>Right</th>
<th>Varicosities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stem varicose veins</td>
<td>□</td>
<td>□</td>
<td>0=No abnormality, 1=Yes, 9=Unknown</td>
</tr>
<tr>
<td>(Do not code reticular or spider varicosities)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Left</th>
<th>Right</th>
<th>Lower Extremity Abnormalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankle edema</td>
<td>□</td>
<td>□</td>
<td>(0=No, 1=Yes, 2=Maybe, 8=absent due to amputation, 9=Unknown)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Left</th>
<th>Right</th>
<th>Amputation level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>(0=No, 1=Toes only, 2=Ankle, 3=Knee, 4=Hip, 8=Not applicable, 9=Unknown)</td>
</tr>
</tbody>
</table>

**Comments**

_________________________________________________________________________________________________

_________________________________________________________________________________________________

<table>
<thead>
<tr>
<th>Artery</th>
<th>Pulse</th>
<th>Bruit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0=Normal, 1=Abnormal, 9=Unknown</td>
<td>0=Normal, 1=Abnormal, 9=Unknown</td>
</tr>
<tr>
<td>Left</td>
<td>Right</td>
<td>Left</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Femoral</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Popliteal</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Post Tibial</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Dorsalis Pedis</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

**Comments**

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

**MD19**
Physical Exam—Neurological Exam

<table>
<thead>
<tr>
<th>Left</th>
<th>Right</th>
<th>Neurological Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Carotid Bruit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Speech disturbance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disturbance in gait</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other neurological abnormalities on exam Specify__________________________</td>
</tr>
</tbody>
</table>

Coding
(0=No, 1=Yes, 2=Maybe, 9=Unknown)

MD20

OMB NO=0925-0216 12/31/2007
## Electrocardiograph--Part I

<table>
<thead>
<tr>
<th>MD Id#</th>
<th>MD Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Rates and Intervals

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventricular rate per minute</td>
<td>(999=Unknown)</td>
</tr>
<tr>
<td>P-R Interval</td>
<td>(hundredths of a second)</td>
</tr>
<tr>
<td>QRS interval</td>
<td>(hundredths of second)</td>
</tr>
<tr>
<td>Q-T interval</td>
<td>(hundredths of second)</td>
</tr>
<tr>
<td>QRS angle</td>
<td>(put plus or minus as needed)</td>
</tr>
</tbody>
</table>

### Rhythm--predominant

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 or 1 = Normal sinus, (including s.tach, s.brady, s.arrhy, 1 degree AV block)</td>
<td></td>
</tr>
<tr>
<td>3 = 2nd degree AV block, Mobitz I (Wenckebach)</td>
<td></td>
</tr>
<tr>
<td>4 = 2nd degree AV block, Mobitz II</td>
<td></td>
</tr>
<tr>
<td>5 = 3rd degree AV block / AV dissociation</td>
<td></td>
</tr>
<tr>
<td>6 = Atrial fibrillation / atrial flutter</td>
<td></td>
</tr>
<tr>
<td>7 = Nodal</td>
<td></td>
</tr>
<tr>
<td>8 = Paced</td>
<td></td>
</tr>
<tr>
<td>9 = Other or combination of above (list)</td>
<td></td>
</tr>
</tbody>
</table>

### Ventricular conduction abnormalities

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>IV Block</td>
<td>(0=No, 1=Yes, 9=Fully paced or Unknown)</td>
</tr>
<tr>
<td>Pattern</td>
<td>(1=Left, 2=Right, 3=Indeterminate, 9=Unknown)</td>
</tr>
<tr>
<td>Complete</td>
<td>(QRS interval=.12 sec or greater)(0=No, 1=Yes, 9=Unknown)</td>
</tr>
<tr>
<td>Incomplete</td>
<td>(QRS interval = .10 or .11 sec) (0=No, 1=Yes, 9=Unknown)</td>
</tr>
<tr>
<td>Hemiblock</td>
<td>(0=No, 1=Left Ant, 2=Left Post, 9=Fully paced or Unknown)</td>
</tr>
<tr>
<td>WPW Syndrome</td>
<td>(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)</td>
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</table>

### Arrhythmias

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<tbody>
<tr>
<td>Atrial premature beats</td>
<td>(0=No, 1=Atr, 2=Atr Aber, 9=Unknown)</td>
</tr>
<tr>
<td>Ventricular premature beats</td>
<td>(0=No, 1=Simple, 2=Multifoc, 3=Pairs, 4=Run, 5=R on T, 9=Unk)</td>
</tr>
<tr>
<td>Number of ventricular premature beats in 10 seconds</td>
<td>(see 10 second rhythm strip)</td>
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</tbody>
</table>

MD21
# Electrocardiograph-Part II

## Myocardial Infarction Location

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<tbody>
<tr>
<td></td>
<td>Anterior</td>
<td>(0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown)</td>
</tr>
<tr>
<td></td>
<td>Inferior</td>
<td></td>
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<tr>
<td></td>
<td>True Posterior</td>
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</table>

## Left Ventricular Hypertrophy Criteria

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</thead>
<tbody>
<tr>
<td></td>
<td>R &gt; 20mm in any limb lead</td>
<td>(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)</td>
</tr>
<tr>
<td></td>
<td>R &gt; 11mm in AVL</td>
<td></td>
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<tr>
<td></td>
<td>R in lead I plus S in lead III ≥ 25mm</td>
<td></td>
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</tbody>
</table>

## Measured Voltage

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<thead>
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</thead>
<tbody>
<tr>
<td></td>
<td>R AVL in mm (at 1 mv = 10 mm standard) Be sure to code these voltages</td>
<td></td>
</tr>
<tr>
<td></td>
<td>S V3 in mm (at 1 mv = 10 mm standard) Be sure to code these voltages</td>
<td></td>
</tr>
</tbody>
</table>

## R in V5 or V6-----S in V1 or V2

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<tbody>
<tr>
<td></td>
<td>R ≥ 25mm</td>
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</tr>
<tr>
<td></td>
<td>S ≥ 25mm</td>
<td></td>
</tr>
<tr>
<td></td>
<td>R or S ≥ 30mm</td>
<td>(0=No, 1=Yes, 9=Fully paced, Complete LBBB or Unk)</td>
</tr>
<tr>
<td></td>
<td>R + S ≥ 35mm</td>
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<tr>
<td></td>
<td>Intrinsicoid deflection ≥ .05 sec</td>
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<td></td>
<td>S-T depression (strain pattern)</td>
<td></td>
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</tbody>
</table>

## Hypertrophy, enlargement, and other ECG Diagnoses

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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Nonspecific S-T segment abnormality (0=No, 1=S-T depression, 2=S-T flattening, 3=Other, 9=Fully paced or unknown)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nonspecific T-wave abnormality (0=No, 1=T inversion, 2=T flattening, 3=Other, 9=Fully paced or unknown)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>U-wave present (0=No, 1=Yes, 2=Maybe, 9=Paced or Unknown)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Atrial enlargement (0=none, 1=Left, 2=Right, 3=Both, 9=Atrial fib. or Unknown)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RVH (0=No, 1=Yes, 2=Maybe, 9=Fully paced or Unknown; If complete RBBB present, RVH=9)</td>
<td></td>
</tr>
</tbody>
</table>

## Comments and Diagnosis

____________________________________________________________________________________
____________________________________________________________________________________

MD22
Clinical Diagnostic Impression--Part I

Heart Diagnoses First Examiner Opinions

<table>
<thead>
<tr>
<th></th>
<th>Rheumatic Heart Disease</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Aortic Valve Disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mitral Valve Disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Heart Disease (includes congenital)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arrhythmia</td>
<td></td>
</tr>
</tbody>
</table>

0=No, 1=Yes, 2=Maybe, 9=Unknown

Peripheral Vascular Disease First Examiner Opinions

<table>
<thead>
<tr>
<th></th>
<th>Other Peripheral Vascular Disease</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other Vascular Diagnosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Specify)_______________________</td>
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</tbody>
</table>

0=No, 1=Yes, 2=Maybe, 9=Unknown

Neurologic Disease First Examiner Opinions

<table>
<thead>
<tr>
<th></th>
<th>Stroke/ TIA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dementia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parkinson's Disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult Seizure Disorder</td>
<td></td>
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<tr>
<td></td>
<td>Other Neurological Disease</td>
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<tr>
<td></td>
<td>(Specify)_______________________</td>
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</tbody>
</table>

0=No, 1=Yes, 2=Maybe, 9=Unknown

Comments CDI ____________________________________________

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MD23
## Clinical Diagnostic Impression--Part II
### Non Cardiovascular Diagnoses First Examiner Opinions

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<tr>
<th>Category</th>
<th>Diagnoses</th>
<th>Options</th>
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<tbody>
<tr>
<td><strong>Endocrine</strong></td>
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<tr>
<td>Thyroid Disease</td>
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</tr>
<tr>
<td>Diabetes Mellitus</td>
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</tr>
<tr>
<td>Other endocrine disorders</td>
<td>specify</td>
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<tr>
<td><strong>GU/GYN</strong></td>
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<td></td>
</tr>
<tr>
<td>Renal disease</td>
<td>specify</td>
<td></td>
</tr>
<tr>
<td>Prostate disease</td>
<td></td>
<td></td>
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<tr>
<td>Gynecologic problems</td>
<td>specify</td>
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</tr>
<tr>
<td><strong>Pulmonary</strong></td>
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<tr>
<td>Emphysema</td>
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<td>Pneumonia</td>
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<tr>
<td>Asthma</td>
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</tr>
<tr>
<td>Other pulmonary disease</td>
<td>specify</td>
<td></td>
</tr>
<tr>
<td><strong>Rheumatologic Disorders</strong></td>
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<td></td>
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<tr>
<td>Gout</td>
<td></td>
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<tr>
<td>Degenerative joint disease</td>
<td></td>
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<tr>
<td>Rheumatoid arthritis</td>
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<td></td>
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<tr>
<td>Other musculoskeletal or connective tissue disease</td>
<td>specify</td>
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<tr>
<td><strong>GI</strong></td>
<td></td>
<td></td>
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<tr>
<td>Gallbladder disease</td>
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<tr>
<td>GERD/ulcer disease</td>
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<tr>
<td>Liver disease</td>
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<td></td>
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<tr>
<td>Other GI disease</td>
<td>specify</td>
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<tr>
<td><strong>Blood</strong></td>
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<tr>
<td>Hematologic disorder</td>
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<tr>
<td>Bleeding disorder</td>
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<tr>
<td><strong>Other</strong></td>
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<tr>
<td>Eye</td>
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<td>ENT</td>
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<tr>
<td>Skin</td>
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<tr>
<td>Other</td>
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<tr>
<td><strong>Infectious Disease</strong></td>
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<tr>
<td>If Yes</td>
<td>specify</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
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<tr>
<td>Depression</td>
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<tr>
<td>Anxiety</td>
<td></td>
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<tr>
<td>Psychosis</td>
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<tr>
<td>Other</td>
<td>specify</td>
<td></td>
</tr>
</tbody>
</table>

**Comments CDI Diagnoses**

**MD24**

Version #8  GM  09-27-05
### Coronary Heart Disease Second Examiner Opinions
(Provide initiators, qualities, radiation, severity, timing, presence after procedures done)

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</tbody>
</table>

- **Congestive Heart Failure**
- **Cardiac Syncope**
- **Angina Pectoris**
- **Coronary Insufficiency**
- **Myocardial Infarct**

**Comments about chest and heart disease**

______________________________________________________________________________________
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### Intermittent Claudication Second Examiner Opinions
(Provide initiators, qualities, radiation, severity, timing, presence after procedures done)

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</table>

- **Intermittent Claudication**

**Comments about peripheral vascular disease**

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### Cerebrovascular Disease Second Examiner Opinions
(Provide initiators, qualities, severity, timing, presence after procedures done)

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</table>

- **Stroke**
- **TIA**

**Comments about possible Cerebrovascular Disease**

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**MD25**