

ARIC

PHYSICIAN QUESTIONNAIRE FORM

Atherosclerosis Risk in Communities

Public reporting burden for this collection of information is estimated to average 6-15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: **NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0281)**. Do not return the completed form to this address.

ARIC Center use only

Version C: 05/31/02

Decedent's Name: _____ Age: ____ Date of Birth: __/__/____ Date of Death: __/__/____

EVENT ID: Sequence Number: Physician's Name _____

Please complete the following and return in the enclosed envelope.

A. MEDICAL HISTORY

1. Are you familiar with the decedent's medical history?

Yes

No

If **No**, skip to Item 5 on Page 3.

2. When did you last see the decedent?

-

Month

Year

3. Did the decedent have a history of any of the following?

	<u>Yes</u>	<u>No</u>	<u>Uncertain</u>
a. Angina pectoris or coronary insufficiency ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Valvular disease or cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Coronary bypass surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Coronary angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

g. If MI **Yes**, date of most recent event:

-

Month

Year

3. (cont'd) Did the decedent have a history of any of the following?

	<u>Yes</u>	<u>No</u>	<u>Uncertain</u>
h. Other chronic ischemic heart disease:....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

i. Stroke (CVA):.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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j. If Yes, date of most recent event: -

Month Year

k. Any non-cardiac condition that might have contributed to this death:	<u>Yes</u>	<u>No</u>	<u>Uncertain</u>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If Yes, specify: _____

	<u>Yes</u>	<u>No</u>	<u>Uncertain</u>
l. Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Cigarette smoking:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Was the decedent taking any of the following medications within four weeks prior to death?

	<u>Yes</u>	<u>No</u>	<u>Uncertain</u>
a. Nitrates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Calcium channel blockers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Digitalis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Beta-blockers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.1. Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.2. ACE or Angiotensin II inhibitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Other cardiovascular drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If Yes, specify: _____

B. DETAILS OF DEATH

5. Are you familiar with the events surrounding the decedent's death?

Yes No

6. Did you witness the death?

Yes No

If you answered **No** to both 5 & 6, skip to Item 14 on page 4. Otherwise, continue with Item 7.

7.a. Was there any pain in the chest, left arm or shoulder or jaw within 72 hours of death?

Yes No Uncertain

If **No** or **Uncertain**, skip to item 8

b. Did the pain include the chest?

Yes No Uncertain

c. Did you think this pain was of a cardiac origin?

Yes No Uncertain

If **No**, specify what you think was the cause:

8. Did the decedent take (or was he/she given) nitrates at the time of the acute episode?

Yes No Uncertain

9. Was coronary reperfusion (intravenous or intracoronary streptokinase or TPA, angioplasty, etc.) attempted during the acute episode?

Yes No Uncertain

10. Was CPR and/or cardioversion performed within 24 hours of death?

Yes No Uncertain

11. Please give time between onset of acute symptoms to death. (We are defining death as the point where spontaneous breathing ceased and the patient never recovered.)

- | | |
|--|---|
| <input type="checkbox"/> More than 3 days (A) | <input type="checkbox"/> At least 1 hour, (F) but less than 4 hours |
| <input type="checkbox"/> 2 - 3 days (B) | <input type="checkbox"/> Less than 1 hour (G) |
| <input type="checkbox"/> 1 day (C) | <input type="checkbox"/> Death instantaneous,(H) no symptoms |
| <input type="checkbox"/> At least 12 hours, but less than 24 hours (D) | <input type="checkbox"/> Unknown (I) |
| <input type="checkbox"/> At least 4 hours, but less than 12 hours (E) | |

12. Would you classify the decedent's cause of death as due to CHD?

- | | | |
|--------------------------|--------------------------|--------------------------|
| Yes | No | Uncertain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

13. If No, what do you believe to be the cause of death?

- | | <u>Yes</u> | <u>No</u> | <u>Uncertain</u> |
|------------------------------|--------------------------|--------------------------|--------------------------|
| a. Pulmonary embolism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Acute pulmonary edema ... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Specify: _____

C. SIGNATURE

14. Form completed by: _____

Signature

15. Date: -- --

Month Day Year

Thank you very much for your help. Please return this questionnaire in the enclosed self-addressed envelope.

OFFICE USE ONLY: 16. Self (A)___ Interview (B)___ E.R. records (C)___